



Legal Issues in Travel Medicine

Karl Neumann, MD, FAAP

Thank you, ISTM members. Once again you have taken the time and effort to answer our query, the latest one on legal issues in travel medicine. Several of you said that the topic is sufficiently important to be formally discussed by international experts at an ISTM conference and that, increasingly, what was once thought to be largely an American problem is hitting home in the rest of the world.

(Also, three respondents suggested that we look into Good Samaritan laws; most countries have them. Many of us have answered calls to medically assist passengers during flights, for example. Apparently, in some countries, it is a crime not to answer such a call. We will discuss this issue in a future issue.)

In this query ISTM members were asked to comment on potential legal problems in their practices of travel medicine. Here are representative responses.

Malpractice Insurance

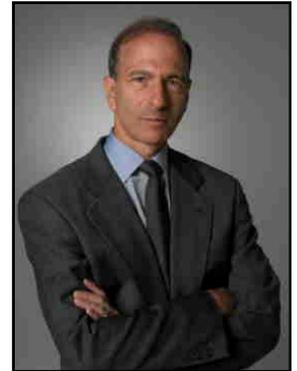
New Zealand: I do not have clients sign consent forms. I believe that consent is implied if they have received written information and have had time to read it and then come for the vaccine. I generally give the patient written information regarding each vaccine at the first visit. In my practice there is usually a gap of minutes to days between the advice given and the vaccine being administered by

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The President's Letter

Dear Friends,

In the fall I wrote to you about plans for a major strategic planning session and subsequently asked for your comments and ideas about the ISTM, its priorities and potential new directions. Thank you all for the candid and thoughtful perspectives you provided in your e-mail responses to me. Your input was critical to our thinking on how to best assure that the ISTM continues to grow and develop and to reach its full potential as the principal international society of travel medicine practitioners.



The strategic planning meeting was held in December 2004, attended by the current and prior ISTM leadership and by other representatives of the ISTM membership. As I mentioned in my previous letter to you, the meeting was facilitated by two former partners of Booz-Allen Hamilton with extensive experience serving global companies in addressing their critical strategic and organizational issues. The purpose of this letter is to report back to you on the **outcomes of this meeting**, the **changes in organization and governance** decided at the meeting, and the **new initiatives** to be launched as a result of the meeting.

All of the leadership and most of the members whose responses we received believed that the society has been successful in advancing its core purpose and goals. All of the leadership agreed that the purpose and goals of the society should not be changed. However, we all believe that the ISTM has greater potential, particularly in expanding its membership, in its role as an international expert body, in its educational agenda, and in strengthening its appeal outside of pre-travel medicine. As a result of the meeting, the ISTM leadership will implement new organization and governance practices to be consistent with a society of the ISTM's size and importance and to more effectively meet its goals.

We believe that the changes in organization and governance will allow the society to be more effective, to be more transparent to our membership, and to better include the efforts of the membership in achieving our goals through a more effective committee structure and process.

The organization and governance changes include the following:

- The Executive Board will meet by telephone every three months in order to conduct ISTM business (rather than just once a year);
- A formal budgeting process has been put in place as a vehicle for critical funding decisions and the prioritization of ISTM expenditures;
- A finance committee has been formed and chartered to oversee the prudent financial management of ISTM resources;
- A development committee has been formed and chartered with coordinating and facilitating the funding of ISTM initiatives;
- In the future the Secretary/Treasurer will become a position elected by the membership (rather than a position appointed by the board as is currently the case);
- A Conflict of Interest Policy will be drafted and signed by all of the ISTM leadership and committee chairs; and
- A working group has been chartered to examine the potential to better utilize professional staff to augment the efforts of ISTM's volunteer resources.

The committee process and structure has been changed to be more effective and to more effectively leverage the efforts of committee participation from the membership, as follows:

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- Each committee will have a charter and annual goals (to be posted on the ISTM website);
- Committees will meet at least two times a year (in any method practical);
- Funding for committee activities will be through the annual budgeting process;
- ISTM members will be solicited for committee participation at least once every two years;
- Appropriate space will be provided at conferences to conduct committee business;
- The electronic communications committee has been disbanded and its role subsumed by the publications committee; and
- The membership committee has been reformed and chartered.

We have launched a number of targeted initiatives with concrete action plans in order to better achieve the ISTM's objectives in the areas of greatest unrealized potential. These initiatives include the following:

- As the leadership believes that there is unrealized potential for membership growth especially outside of North America, the ISTM will renew its efforts to continue to grow the membership and therefore its impact within the international travel medicine professional community;
- We will endeavor to structure relationships with national societies to further our goals;
- New categories of membership are being examined to target members of national societies as well as practitioners in developing countries;
- A membership committee has been formed to drive the ISTM's efforts in this area;
- The Host Country Committee has been charged with outreach to potential new members in developing countries;
- The Migrant and Refugee Health Committee has been charged with growing

membership within that professional community;

- An action plan has been developed to enhance the ISTM's recognition as an international expert body in travel medicine;
- The ISTM will begin issuing consensus statements (expert guidelines) on issues of importance to travel medicine and the publications committee will oversee this effort (our goal is to issue two expert guidelines per year); and
- In addition, the ISTM will seek to have representation within relevant global health bodies - as an initial step we will seek observer status at the World Health Organization.

An action plan has been developed to further the achievement of the ISTM's educational agenda:

- The education committee has been charged with developing and managing the educational activities of the ISTM;
- The goals of the education committee over the coming year will be to prepare a monograph on how start a travel clinic, make educational slide sets available on topics of importance to travel medicine practitioners, develop a speakers bureau identifying expert lecturers, and explore distance learning as a vehicle to create additional educational opportunities; and
- The exam committee will continue to manage the provision of the exam and will consider the possibility of exam preparation courses.

Finally the leadership of the ISTM has recognized that Migrant and Refugee Health is a critical area of strategic investment for the society. However we believe that our approach to this professional community needs to change. We have asked the Migrant and Refugee Health Committee to develop an action plan to achieve the following objectives:

- Develop and propose initiatives to increase ISTM membership within the Migrant and Refugee Health professional community;

- Develop and propose specific programs and initiatives to serve the Migrant and Refugee Health Community within the ISTM; and
- Present and discuss this program at the next quarterly meeting of the ISTM Executive Board.

As you can see, we have developed an ambitious agenda, an agenda which I believe will ensure that the ISTM reaches its full potential in advancing the science and practice of travel medicine. We

are excited about the future prospects of the ISTM and by the program we have developed to bring us into the future. You should expect that the changes we have made will be reflected in future communications to you, at the next CISTM, and in the organization and activities of our committees. Some of the changes that we have endorsed will require changes to our bylaws and you will be asked to contribute your support by voting for these by-law changes.

Ultimately, the success of the ISTM and its contribution to the health of travelers will depend on you. I will continue to actively seek your participation in the efforts of the Society as we endeavor to meet our goals. I look forward to seeing all of you in Lisbon and I appreciate your continued engagement and passion in building an even more successful ISTM.

Brad Connor

"We are excited about the future prospects of the ISTM and by the program we have developed to bring us into the future."

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the practice nurse. Our New Zealand “no faults” compensation system for medical error reduces risk of liability. But if the error causes a significant loss to a medical insurer they may well seek compensation from the travel medicine practitioner who made the “error”... I am very cautious about signing “fit to travel” disclaimers from insurers.

U.S. I recently spoke to a well-regarded malpractice lawyer about another matter, and mentioned my travel medicine practice, which constitutes about 10-15% of my internal medicine practice. He felt very strongly that I should report this to my insurance carrier, even if it meant higher insurance premiums. He thought that advising patients about health and safety overseas is quite a different risk than practicing internal medicine in a mid-western city of about 200,000 people. Since I did not follow his advice (at least, yet), I can not report what my insurance company’s reply is.

U.K. I was involved in litigation some years back. A traveller developed Guillian Barre (GB) after oral polio vaccination (OPV). The claimant stated he would not have accepted the vaccine if he was made aware of the very rare risk of GB. The case came down to the whether the rare adverse event should have been discussed with the claimant.

It was settled out of court. There is no evidence that GB is causally linked to OPV. What is always a problem in my practice is the level and detail of discussion about adverse events. My defence union informs me that to obtain informed consent, I need to detail all adverse events contained in the data-sheet, on all vaccines and drugs administered or prescribed. I believe this is not in the best interest of my clients as I need to educate them on disease prevention and other important health issues in my 20 minutes. I can either practise defensively or morally.

Australia. Deep vein thrombosis has been much in the news in the past few years with many law suits, albeit most of them against airlines, but some have involved physicians. Many of the suits are described on the web site: AirHealth.org

U.S. Rather than give the patient a verbal litany of all possible adverse effects, the patient can be given Vaccine Information Statements (VIS) to read and then sign that they have done so, understand the contents, and have had their questions asked prior to immunization. VISs are available at <http://www.cdc.gov/nip/publications/vis/>, though admittedly these are American information products for vaccines used in the U.S. (we are probably pioneers and leaders in this area since Americans are so quick to sue these days), so possibly not helpful to everyone. Others could develop their own, as long as they had a mechanism for updating them on a timely basis.

U.S. As a medical-legal consultant, I can tell you that vaccine litigation is becoming more prominent. According to standards, everyone should be given a VIS before being given a vaccine. I recommend consent forms which state that you gave the VIS and they are consenting to the vaccine.

U.K. I have been an expert witness in a number of cases following patient deaths, principally involving failure by clinicians to test for or diagnose falciparum malaria. An additional issue has been the liability of community pharmacists when recommending chemoprophylaxis. (I’m presenting a poster on a related issue, the quality of pharmacy chemoprophylaxis advice, in Lisbon.)

U.K. For physicians going to work overseas, my understanding is that normal duties of care apply, plus perhaps problems with ‘practising’ in a foreign country where one is not licensed, plus uncertainty over whether MDU or MPS coverage applies. (MDU and MPS are medical defence mutual societies, based in London, that indemnify most non-US physicians against malpractice.)

U.K. That old chestnut, the giving of advice telephonically, often to complete

strangers, comes to mind. Staff needs to be reminded that liability exists whether the caller is a patient of the practice or not, and regardless of whether the caller pays for the advice or not.

U.S. No telephone advice for unregistered, unknown patients. If they inquire about cost of visit and vaccines, the receptionist can provide that information. (Please do not use the word “clients,” it is something insurance companies use to demean the value of physicians.)

U.S. Here is the consent form I have travelers sign:

Vaccines, health precautions, insect protection and malaria prophylaxis are extremely helpful but do not guarantee illness prevention. IF YOU BECOME SERIOUSLY ILL DURING OR UP TO A YEAR AFTER TRAVEL, IT COULD BE MALARIA. SEEK LOCAL CARE OR EVACUATION AT ONCE. Contact your physician or our clinic upon your return.

Medical Consent for services: I understand that vaccines can in rare instances cause complications including death. I also understand that the chance of serious harm is less than 1 in 1,000,000 and that these vaccines and medications are FDA approved. I agree to accept this risk to decrease my chances of contracting a serious preventable disease. I also give permission for you to provide my personal physician with a list of vaccines that I have received.

We do not accept any insurance.

Signed _____ Date _____
Traveler, Parent or Guardian

U.S. I believe implied consent is holding out your arm and sitting still for the shot. I do have a handout on yellow fever vaccine I give to each recipient of that vaccine. For telephone advice for travelers unknown to us, my receptionist looks up an accepted web site and reads off what they list for that country in this language: “Our concerns for travel to Zimbabwe are....” That way she has not given medi-

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cal advice on the phone to someone I have never met.

U.S. All my patients sign consent forms after my risk assessment and after I have discussed their options and costs that might be involved. The consent form includes declaration of pregnancy/intended pregnancy, risk assessment, and treatment plan. A copy is given to the patient, another is scanned into our computer notes. I have not taken out any additional malpractice cover, though I have considered it. I am aware that a nurse has been sued for not warning a traveler about Bilharzia at a destination, where the illness was contracted.

Expatriate posting

South Africa. A specific problem under South African legislation is that employers are forbidden from discriminating against individuals on the basis of their HIV status. Employers are also forbidden from testing and from knowing their employees' HIV status, unless of course the employee volunteers to divulge his status. The employer is at the same time obliged to take the best possible care of his employees, and not expose them to unnecessary hazard. These two noble aims may obviously conflict at times when it comes to expatriate postings.

Considerations will vary with jurisdictions obviously, but the concept of ‘duty of care’ that employers have towards their employees also comes into play; e.g., a nuclear power company would be negligent if it sent pregnant employees into a radiation zone.

There are also cost implications for employers (e.g., what will be the cost of rescuing an immunocompromised individual who develops a complicating illness in an environment where there is no adequate medical care?). The well being of the employee may also be jeopardised in such a situation if evacuation is delayed or not possible due inclement weather, for example. An additional consideration arises if the employee is under consideration for posting to a critical position, when fellow employees and facilities may be placed in jeopardy in the event of critical employee illness.

The ways around this dilemma appear to be to let the employee know that it is not in his best interests to accept the posting, and to advise the employer of the employee's lack of fitness for posting, without revealing any diagnosis. The problem is then effectively handed back to the employer.

Replies from Germany, U.K., and Italy. Similar anti-discrimination legislation, and covering other diseases and handicaps, is in effect in the European Union.

Adventure Travel

U.S. My experience with travel-related liability issues is that they have all been settled without a court verdict, leaving little precedent. These are actual incidents that took place abroad, and not pre-travel events.

Fifteen years ago and longer, adventure travel companies used to actively recruit physicians onto their trips by offering substantial discounts. Most physicians found that their liability insurance would not cover them on such trips. The adventure travel companies asked for some legal opinions, and found that if the doctor accepts a discount for the trip, this makes him/her an employee of the company, and therefore liable for the care given. This would negate the “good Samaritan” interpretations of a bystander offering care in good faith.

However, I'm aware of only one suit of a doctor on an adventure travel trip, and that doctor was not a “trip doctor,” just a client like anyone else. The doctor was an obstetrician, and the patient died of an illness that could have been compatible with high altitude pulmonary edema, but this was never clear. The suit was eventually settled, so no precedent was set. Trip leaders who were not doctors have been sued, but again, the suits were settled.

On a note that has always been disturbing to me, at least one adventure travel company has decided that carrying a group first aid kit could be a liability, especially if non-medically licensed persons used these medications on a client. However, I've always argued that taking a

group of people into a remote, medically unserved environment would necessitate having medications and first aid items along. The company would prefer that each individual have their own prescriptions, which makes sense at first, until you think about having nitroglycerin, injectable pain medications, etc., for unlikely but serious events that each person may not have individually prepared for.

U.K. Malpractice insurance generally does not cover care out of country. When I go overseas with a group, I have them sign a waiver so I cannot be sued, and, at the same time, include consent to treat if they are a minor, to be signed by the parent/guardian.

Karl is the editor of NewsShare.

An Invitation to Nurses attending CISTM9 in Lisbon!

The Practice and Nursing Issues Committee (PNI) invites all nurses attending the conference to the *Nursing Welcome Reception on Sunday May 1.*

- Come meet and greet colleagues from around the world
- Learn about some conference highlights
- Hear from colleagues in the UK about the Travel Health Nurses Forum (5,000 members and growing!)
- Enjoy refreshments

DATE: Sunday May 1st

TIME: 15:00-16:30 (3 pm-4:30pm)

WHERE: Conference Center
Restaurant (river view) –
ESPACO TEJO

(Directions will be provided at the conference registration desk)

Tsunami Late-Breaker Sessions added for Lisbon

In addition to the excellent program previously planned for CISTM9 in Lisbon, we have added two Tsunami-related sessions featuring high profile individuals with first hand experience.

A symposium entitled "Tsunami: Lessons Learned" will take place on Wednesday afternoon, May 4, with the following topics and speakers:

Mechanism of Natural Disaster Preparedness:

Adelheid Marschang
International Federation of Red Cross and Red Crescent Societies
Geneva, Switzerland

Communicable Disease Risks after Natural Disasters:

Maire A. Connolly
World Health Organization
Geneva, Switzerland

Asian Tsunami: Lessons in Disaster Management from Aceh:

Professor Meng Kin Lim
National University of Singapore

On Tuesday evening, May 3, from 1845-2045, there will be a CISTM9 Special Session: "Tsunami: Personal Experiences of Medical Personnel in Affected Areas." We have secured sponsorship for this session so that a light snack will be served prior to the session.

Chairs:

Bradley Connor, President ISTM
New York, USA

Douglas Quarry, Medical Director International SOS Online
Sydney, Australia

Michael Callahan, MD (USA)
CIMIT Mass Casualty Care/Division of Infectious Diseases, Massachusetts General Hospital Boston Massachusetts
Sponsoring Agency: Rescue Medicine Aceh Disaster Relief: Transition of mass casualty care medical needs between the December 28th airlift and the Project Hope/Combined Support Group Mission aboard USN Hospital Ship *Mercy*

Mathew Klein, MBBS (Australia)
Department of Foreign Affairs and Trade, Canberra, Australia

Sponsoring Agency: DFAT Australia
Phuket and Bangkok, Thailand
Medical Support of Australians in Phuket

Roger Farrow, MD

International SOS, Singapore
Sponsoring Agency: International SOS Assistance
Phuket, Thailand
The International SOS Response - a Perspective from Phuket

Eli Schwartz, MD (Israel)

Tel Hashomer Hospital, Israel
Sponsoring Agency: Latet (Israel-based NGO)
Trincomalee, Sri Lanka
Early Days Medical Issues in Eastern Sri Lanka

Mika Shigematsu, MD (Japan)

National Institute of Infectious Diseases, Tokyo
Sponsoring Agency: JICA & National Institute of Infectious Diseases
Banda Aceh
Qualitative Rapid Assessment for Infectious Diseases and Identification of Priority Areas for Japanese Aid 1945-2000

Dipti Patel, MBBS (UK)

BBC, London
Sponsoring Agency: Occupational Health Unit, British Broadcasting Corporation (BBC)
Preparation and Health Problems Encountered by Journalists Deployed to Tsunami-Stricken Areas

Vernon Ansdell, MD (USA)

University of Hawaii and Kaiser Hawaii, Honolulu, Hawaii
Sponsoring agencies: Aloha Medical Mission and International Medical Corps
Aceh, Indonesia
Post Tsunami Experiences in Aceh Province

Lynda Redwood-Campbell, MD (Canada)

McMaster University, Hamilton, Ontario
Sponsoring Agency: ICRC
ICRC Field Hospital, Banda Aceh
Ongoing Medical Care Delivery in a Red Cross Field Hospital

Tsunami Report

*Marc Timothy Malcolm Shaw,
FRNZCGP, FACTM, FFTM, B.Med.Sci., DCH,
DRCOG, Dip. Trav. Med. (Glasgow)*

One of the most powerful earthquakes in a century hit Asia on Boxing Day. The radio announced the details "... 8.9 magnitude underwater earthquake ... off Sumatra ... walls of water ... 10 metres high ... 11 countries affected..." I was in bed when I heard of the disaster, day off, comfortable, and wondered just what the horror of it all would have been like.

As the number of dead and dying rose higher and higher, I wanted to help. Helping is the first response for us in the medical profession. After all, it's our training. Saw the re-runs on TV and decided that I wanted to get there. Who to call? All the humanitarian organizations want 'experienced personnel' for their work, but how do you get experience? An old mate rang. He'd been thinking the same. He called a TV reporter mate of his, figuring that TV exposure could raise the profile and funds would follow. 'Did I want to go?' Don't get a chance like this again.

Four days later the three of us were sitting with a TV cameraman in an Air New Zealand plane on the way to the island of Nias in Indonesia. We had no idea what we were going to do, but we had accumulated 30 packs of medical supplies and we had a determination to use them where they were needed. We had got caught up in the spirit of it all; cowboys flying in to help, that's what it felt like. When I look back on it, you need to be more than a cowboy, much more.

It was a remarkable trip and I learned so much about what it means to be in a disaster. More than a radio comment, more than a newspaper article read with a *cappuccino* in the morning before work, and much more than life for many a person involved in the smashing, swirling horror over a few hours.

Our itinerary: one day travel to Indonesia, then two days to get to the troubled area in a small boat that seemed to chug with a beguiling rhythm that shut out the terror images that we were anticipating. Arrived at 0700 and went ashore to what had been a flourishing community. The

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town of Sirombu was balanced on an out-jutting into the sea, and the tsunami had whipped around and hit the town from both sides, taking out the market, the jetty road and the whole of the seaside section of the town. Ten kilometers further towards the equator, and some real damage had been done. A couple of towns, one by the sea and its sister just 1 kilometer inland had been completely annihilated by waves that came in over 6 meters high. You could tell it was 6 meters because at that height the coconuts had been sheared off by the force of the water. The 15 meter trees still had them attached.

Silence in the remains of the towns. No one talking, nothing to say. Quiet. Respect. A man in a yellow T-shirt sat looking at his hands; recalling former life now gone. The towns had lost over a third of their population of 500. One hundred died trying to get to a church for shelter. He hadn't lost his family but everything else had gone. No house, no village-folk, no more history. His affect was flat, and I was reminded that death was not the only loss in such communities. Photos of families, smiling, lay in dried mud beside wrung-out toys and children's shoes. It actually felt uncomfortable to look at them initially. Then I reminded myself that the best way to salute these unknown lives was by studying them in some sort of prayer. What does one give to a man who has lost everything... money (how much is enough?), clothes, food and water? I don't know.

Six clinics in four days, our packages of medicines and wound care product soon

went. Lines of folk to see, but of course there would be with only 6 doctors on an island the size and population of Bali. What did we see? Lumps and skin conditions festering over 5 years. We saw common family medicine in all its colours, children in Nias with ear problems who still scream when they are examined, corrupt officials demanding to 'jump the line' to have their servicing. We smile and do it... easier to go with the rhythms than go against them. After all

this we saw tsunami victims, but very few for those that survived strangely had little disorder about themselves. The thing that got me was the line of over 100 folk waiting to be seen. Whilst we were there this line got bigger, never smaller, and personal exhaustion would force us to call it a day. I wonder how much use I really was. Being a cowboy is too easy, needs a little more honesty than this-for the work is hard and long. It needs planning and a structure.

Disaster Medicine Preparation:

Many of us want to go to help with such emergencies, either through compassion or personal need. For those that get to go, it is essential that they are aware of the risks and know the measures to be taken to minimize those risks. Little doubt that they should inform themselves regarding immunizations, prophylactic medications and appropriate disaster-relief education. I ensured that all of us were up-to-date with: tetanus/diphtheria, hepatitis A and B, typhoid, polio, measles, and cholera. We all took doxycycline as an antimalarial, for its added protection against leptospirosis, plague and a variety of other disaster-potential diseases. Rabies and Japanese encephalitis were risks in the region, but there really needs to be a 3-week lead in for them to be adequately protective. We didn't have this luxury, so I advised our group and told them to run if they saw a mad dog approach! Mossie bites? Repellent, 30% DEET, that's the 'go' for us!

Then there was all the other stuff we needed to be aware of: food and water protection (hand alcohol-cleanser and handwipes are good for this), sunscreen (very hot and humid there, protection essential). Packing a personal kit is an individual experience, and familiarity flourishes a mind that answers to the need of a travel occasion. We all do it, we all know stuff we tell others to take, but, boy, when you have to sit down and do it for yourself! I tried my best to do this, and did pretty well actually only forgetting to take a photo of my wonderful partner! We still talk, but I have to say there were a few issues!

Because the risk for injury during and after a natural disaster is high, folk who travel to tsunami-affected areas or to other disasters will need sturdy footwear to protect their feet from widespread debris present in these areas. I can vouch for the calamity underfoot that you walk upon. Tetanus is a potential health threat for persons who sustain wound injuries; witness the outbreak in Banda Aceh.

Psychological/Emotional

Because of the tremendous loss of life, serious injuries, missing and separated families, and destruction of whole areas, I feel that it is essential to recognize the disaster situation as extremely stressful. Keeping an item of comfort nearby, a family photo, favorite music, or religious material, for example, can often offer personal and professional comfort in such situations.

With this trip, I had learned the first lesson in disaster care. Just going to assess what is required is not enough; it is essential that those that go to help do so with a purpose and with good organization. In fairly basic and sometimes primitive conditions, we ran health clinics for four days seeing folk who simply just don't get to see a doctor. Some benefit we gave to a few at least. And there was huge personal reward of practicing day to day tropical medicine.

Marc is also a traveller and observer of fine humour.

He has recently been appointed Associate Professor at James Cook University, Australia. He is the Medical Director of the Worldwise Travellers Health Centres of New Zealand.

Calendar: Travel Medicine Conferences, Courses, Educational Travel

(Note: This calendar is a service for the travel medicine community. The listings come from reputable individuals within the community but are not checked or necessarily endorsed by ISTM.)

Conferences, 2005

Wilderness Medicine in Manitoba, (Canada): Clinical issues in Immunology and Travel Medicine. April 1-2. Focus on practical issues in counselling travelers: immunization of health care workers, TB detection, drug interactions, altitude, cruising, emerging zoonoses, third world dentistry, skin cancer, and psychiatric issues. Faculty: nurses, medical specialists, entomologist, veterinarian and pharmacologist. Eclectic topics and review of basics. Course for those new to travel medicine or tropical medicine program. Website: www.skylarkmedicalclinic.com for complete program. Contact: Gary Podolsky MD at 204 453 9107

London School of Hygiene & Tropical Health: Short Course in Travel Medicine. April 4-8. London. Fundamentals of travel medicine for physicians and nurses: operating a travel clinic, access to information, vaccines, fitness to travel; travel-related diseases, legal aspects, deep vein thrombosis, preparing long term travelers, and other topics. Information: Registry, 50 Bedford, Sq. London WC1B 3DP UK. Email: shortcourses@lshtm.ac.uk Internet: <http://www.lshtm.ac.uk> Tel: +44 (0) 20 7299 4648 Fax: +44 (0) 20 7323 0638

9th Annual Travel Health Conference of Alberta Association of Travel Health Professionals. May 27-28. Banff, Alberta, Canada. Expert speakers will discuss long term travelers, flying after diving, vector borne disease, STI risks and many other topics. Contact: Sandy Phillips @ sandy.phillips@calgaryhealthregion.ca Tel: (403) 934-3454

XVIth International Congress for Tropical Medicine and Malaria. September 11-15. Marseilles, France. Overview of recent advances in understanding and management of tropical diseases and of challenges ahead. Information: J.M. Milleliri Tel: 04 91 15 01 44 Fax: 04 61 15 01 46 E-mail: imtssa.asmt@wanadoo.fr

Manitoba 4th Annual Travel Health Conference. April 21-22. Winnipeg, Canada. Forum for health professionals to ex-

change travel medicine information. Speakers are national and international experts including three members of the National Committee to Advise on Tropical Medicine and Travel. Information: Jill Evison, WRHA, 490 Hargrave Street, Winnipeg, Manitoba R3A 0X7. Telephone: 204-940-2081. Email: jevison@wrha.mb.ca.

9th Conference of the International Society of Travel Medicine (CISTM). May 1-5. Lisbon. Biennial meeting of the International Society of Travel Medicine brings together international experts for the largest and most important conference in travel and migration medicine. Intended for health care professionals, the travel media and travel industry, and manufacturers of travel health-related products. Contact: Frank von Sonnenburg, Section on International Health, Georgenstrasse 5, D-80799 Munich, Germany. Tel. +49 89 2180 3830. Fax: +49 89 33 60 38. Email: istm_europe@csl.com. Website: www.istm.org.

8th International Symposium on Maritime Health. May 8-13. Rijeka, Croatia. Organized by International Maritime Health Association and local organizers, with support from WHO, IMO, ILO and ITF. For health professionals, educators, and legislators. Faculty of international experts. Conference held aboard cruise ship originating in Venice, sailing along Adriatic coast, and visiting the cities of Rijeka and Dubrovnik. Official language: English. Contact: 8th ISMH Secretariat, RI-AK, Verdieva 6, 51000 Rijeka, Croatia. Tel: +385 51 312-312; Fax: +385 51 312-333; e-mail: secr-ismh8@ri-ak-tours.hr; web address: www.ismh8.com.

1st International Conference of the Journal of Travel Medicine and Infectious Disease. November 10-11. London, U.K. Organized by Elsevier Publishing in association with Travel Medicine and Infectious Disease Journal. Conference will bring together leading experts for a comprehensive and topical programme focusing on the latest research and policy in travel medicine and infectious disease. **Website:** www.travelmedicine.elsevier.com **Secretariat:** Sophie Peters, Confer-

ence Secretariat, Elsevier, The Boulevard, Langford Lane, Kidlington, Oxford OX5 1GB, UK Tel: +44 (0) 1865 843643 Fax: +44 (0) 1865 843958 Email: s.peters@elsevier.com

54th Annual Meeting of the American Society of Tropical Medicine and Hygiene. December 11- 15. Washington, DC. Details about registration and abstract submission will be posted in early 2005. Contact: ASTMH, 60 Revere Drive, Suite 500 Northbrook, Illinois 60062. Tel: (847) 480-9592; Fax: (847) 480-9282. E-mail: astmh@astmh.org. Website: www.astmh.org

2006

North European Conference on Travel Medicine. June 7-10 2006. Edinburgh. A collaborative conference organised by the International Society of Travel Medicine and the travel medicine societies and organisations of Northern Europe. Website: www.nectm.com. Information: In Conference Ltd., 10B Broughton Lane, Edinburgh EH1 3LY, Scotland, UK. Tel: +44 131 556 9245. Fax: +44 131 556 9638. E-mail: NECTM@in-conference.org.uk.

Courses/Educational Travel

World Wide Learning: Two-week Courses in Clinical Tropical Medicine: Moshi, Tanzania, March and October 2005. Manaus, Brazil, May and November 2005. Kolkata, India, April and November, 2005. Also, Tropical Dermato-Venerology and Leprosy, Moshi, Tanzania, November, 2005. Organized by the Institute of Tropical Medicine, Berlin. Hospital- and community-based courses include participation in outpatient clinics and ward-rounds in medical, paediatric, ophthalmological, dermatovenerological and gynaecological departments; laboratory practice; tutorials, lectures, community project visits. Knowledge of spoken English required. Written examination with certificate in Clinical Tropical Medicine for successful candidates. German CME credits and recognition awards available. Information: Dr. Ute Schwarz, Institute of Tropi-

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cal Medicine, Spandauer Damm 130, 14050 Berlin, +49 30 30116 794 / +49 30 85074 630. Email: ute.schwarz@charite.de

Clinical Priorities in Tropical Countries.

June 13 – July 1, 2005. 3-week course at Ilala District Hospital, Dar es Salaam and St. Francis Designated District Hospital, Ifakara/Tanzania. Organizer: Swiss Tropical Institute, Basel. Course coordinator: Christoph Hatz, MD, in collaboration with medical centers in Africa, Asia, and Europe. Purpose: training medical professionals working at district level in developing countries. Course includes ward rounds, group work on case studies, laboratory experience, design of diagnostic and curative working tools for specific situations, and teaching health staff. One week reserved for technical and practical issues managing HIV/AIDS patients. Certificate available for participants who score well on exams. Mastery of English necessary. Information: Swiss Tropical Institute, Course-Secretariat, P.O. Box CH - 4002 Basel/Switzerland Telephone +41 61 284 82 80 Fax +41 61 284 81 06 E-mail: courses-sti@unibas.ch CHF 1500.

The Gorgas Advanced Course. Lima, Peru. August 15-26, 2005. 2 weeks of bedside clinical experience on 36-bed tropical disease unit. Sponsor: Gorgas Memorial Institute. Site: Tropical Medicine Institute (IMT), Universidad Peruana Cayetano Heredia. Course provides experienced clinicians hands-on exposure to large numbers of patients in a short period of time. Educational Format (in English): 1) Monday-Friday of 2 consecutive weeks; 2) 5 participants & 1 senior sub-specialty trained faculty per clinical group; 3) 3 hours/day seeing inpatients and 3 hours/day seeing outpatients; 4) Case conferences/CPC every day; 5) Parasitology laboratory review session; 6) One formal lecture/day; 7) Weekend excursion: Veruga Bridge, inter-Andean valleys endemic for bartonella and leishmania; ascent to 4,800m. Peru has an unusually wide spectrum of tropical diseases (full listing on the website). IMT is major tropical disease referral center. 80 CME hours. Course Directors: Dr. Eduardo Gotuzzo (IMT) <egh@upch.edu.pe>, Dr. David O. Freedman, (Gorgas/UAB). World Wide Web: www.gorgas.org Click on GORGAS ADVANCED COURSE. Telephone: +1 205 934 1630 Fax: 205 934 5600 E-mail: egh@upch.edu.pe

NewsShare

the Quarterly Newsletter of the International Society of Travel Medicine

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