



The President's Column

Prativa Pandey, MD



Dear Colleagues,

I am very pleased to report that the work of the Society is progressing well. The new Executive Board which took office at our last meeting in Lisbon is a hardworking, dedicated group. One of the first tasks of the Executive Board was to get all of the Board members including committee chairs to declare and sign conflict of interest statements and this has been accomplished.

The Executive Board will be focusing on several new tasks in the coming months. Several committees of the Society will be working jointly to develop guidelines for evidence-based clinical practice. This will pave the way to set standards for the practice of travel medicine. Other educational initiatives include: developing teaching tools in travel medicine e.g travel medicine slide sets, monograph on how to start a travel clinic, and interactive clinical case discussions, for example. The feasibility of having the Society run courses to help individuals prepare for the certificate of knowledge examination (CTH) is also being explored.

To increase web based services offered to members, a separate web editor position has been created. Applying for research grant awards – awards which will be offered annually - will soon be web-based. Each committee of the Society will also have a presence on

Continued on page 2

Are You a Good Samaritan?

Karl Neumann, MD, FAAP

Good Samaritan Doctrine: "a legal principle that prevents a rescuer who has voluntarily helped a victim in distress from being successfully sued for 'wrongdoing.' The purpose is to prevent people from refusing to help for fear of legal repercussions if they make mistakes in treatment".

Health care professionals have moral and ethical obligations to give medical assistance to travelers and those obligations supersede any legal ramifications of their actions. This is the near unanimous opinion of the eighty ISTM members responding to a questionnaire asking for their thoughts on this subject.

Virtually all respondents have offered medical assistance and would do so again, but about half of them would not do so unconditionally, with many giving inconsistent answers to different questions. Typically: "I would rather be sued than deal with my conscience." But, "I help if it appears that my assistance will make a difference."

No respondent has experienced legal complications from providing medical help but many had "heard" or "read" of such cases. Only one respondent cited an example: a South African doctor driving in Mozambique hit a child who ran into the road. He stopped, rendered assistance, and took the child to hospital. The child died. The doctor was arrested at the hospital and spent three days in jail. (However, as wrongful the arrest may have been, this physician was not merely a Good Samaritan. Ed.)

Here are some interesting responses to our questions:

Should health care professionals be Good Samaritans?

"I often assisted trekkers in Nepal but not local people unless it is absolutely necessary. Assisting locals undermines local health systems - which tourists are often unaware even exist."

"In the U.S., each state has Good Samaritan laws, and they vary considerably. All the laws are listed at: http://www.aedhelp.com/legal/downloads/aed_legislation_summary.pdf ..."

"Some Canadian provinces have Good Samaritan laws. See <http://www.canadianlawsite.com/goodsamaritan.htm>... Quebec is unique in requiring people to help a person in peril...."

"Generally, I think one should respond - perhaps make it clear to the patient what level of competence they have, and get a verbal OK with a witness..."

"I would be careful in offering help if it involves the jurisdiction of the U.S."

"Morally, absolutely. But sometimes it's hard to know if you are exceeding your range of competency, especially in a "foreign" environment, often with inadequate resources."

"In Portugal, medical professionals must respond, if only to say there's nothing they can do."

"As a fellow human being I try to help where I feel I am the best (or the only) one available. But traveling medical professionals should avoid going overboard in dispensing unofficial medical care which circumvents the established health care system."

"I can recall six occasions when I have done so: two aboard aircraft and four on the road. Not once was I thanked. One roadside case resulted in my being required, without remuneration, to take time from my practice to testify in court. One party sued another, not me. These incidences have increased my cynicism regarding society, and contempt of

Continued on page 2

In this issue..

The President's Column	1
Are You a Good Samaritan?	1
Research Grants Available	2
Edinburgh 2006	3
ISTM Committee Reports	4
Calendar	See Webpage

Calendar of Travel Medicine Meetings now on the Webpage

Please see the ISTM web page for the Calendar of upcoming travel medicine meetings, the most extensive listing of its kind. This change will help in keeping the Calendar current and gives us additional pages for ISTM and travel medicine news.

"The President's Column," cont. from p. 1

the website. These committee websites will detail committee charters, membership, and activities to make it simpler for members to see the range of committee activities and to interact with queries and suggestions.

Blackwell Publishing will be publishing *Journal of Travel Medicine* (JTM) starting January 2006. This will increase visibility of the Journal due to their worldwide sales and marketing. It will be easier and quicker for authors to submit manuscripts via the new web based system. This is expected to improve the impact factor of the Journal. I strongly encourage you to publish your research in JTM. Also, as of January 2006, JTM will get a new cover that has been voted upon by the Executive Board. I sincerely hope that you will be pleased with the new look. Please see Committee report, page 5.

All of us know that the most vulnerable group of travelers is the VFR (visiting friends and relatives) travelers. The Migration and Refugee Health Committee of the ISTM will be focusing on travel medicine implications of VFR travel as their priority this year. Several educational initiatives of this committee will soon be featured on the web.

Studies have shown that only a fraction of travelers see travel health professionals before they travel. We feel a strong need to partner with travel industry professionals to spread the word about our specialty and how we promote traveler safety and well being. The upcoming World Summit for Peace through Tourism conference will serve as a forum to develop a relationship with travel industry groups, and together develop ways to educate the traveling public.

We continue to explore relationships with international bodies like the World Health Organization. With the passage of the international health regulations, ISTM members can help play a role in their own countries, making available relevant information about potential public health threats that may first emerge in travelers. We already have expertise in this area. Our own GeoSentinel surveillance network is effectively monitoring emerging health threats around the globe, and can quickly disseminate this information.

ISTM partners with nine European travel medicine societies to hold the North European Conference in Travel Medicine (NECTM) in Edinburgh from June 7-10, 2006,

Continued on page 8

"Are You a Good Samaritan," continued from page 1

lawyers. Nonetheless, I would assist again. Not because I'm a physician, but because I'm a human being. Rendering aid is casting a vote for a kinder, more humane society; refusing is voting for a society in which every one is condemned to suffer alone."

"Physicians are fortunate that we – often through the efforts of others – have our professions. We have an obligation to use our skills..."

"I've volunteered three times in airplanes: for fainting, nose bleed, and hyperventilation. It's my moral duty.... It beats just sitting for long periods, might lead to something exciting, makes one feel part of "the team," meet nice people, and get special attention (like a bottle of champagne). Mostly, I like being a doctor."

Should health care professionals carry medical equipment/medication when they travel?

"I carry a gadget for CPR mouth-to-mouth protection."

"For Africa, I carry a medical kit, for myself and my travelling companions. ...whole countries have no EMS services."

"I carry a mini trauma kit in my hand luggage."

"A uniform kit for all medical professionals would be a great idea."

"I give medicines from my personal supplies when the airlines do not have them."

"I keep my ACLS/BLS certificates up to date."

"I carry a stethoscope, diagnostic set and sphygmomanometer in my laptop bag."

"I used to carry a medical emergency box in my automobile's trunk but found that the drugs were usually out of date and/or damaged by the heat so I no longer do so."

"All airlines should carry the same equipment and same medication."

"I have ceased doing so. To carry them in my car is an invitation to thieves, and to carry them in my luggage aboard an aircraft causes too much inconvenience with security personnel."

"I always carry a stethoscope and usually an otoscope and Z-pak."

"On a key ring I carry nitro and a beta blocker. In my shaving kit I have epinephrine, Benadryl and a straight catheter."

"My small first aid kit with basic medications came in handy once when someone had an allergic reaction."

"I have gloves and a one-way valve CPR mask in my car trunk."

"Health care professionals should NOT have to carry medical supplies, airlines should. And they should be standardized."

"I don't feel obligated to carry equipment other than our own first aid supplies."

Anecdotal Experiences

"Using a stethoscope, you can't hear heart sounds over the noise of the jets. I thought that an unresponsive, pale and pasty guy was dead. I was getting ready to shock him. Then he groaned and moved. It was a case of syncope."

"...stethoscopes are helpful on planes even if you can't hear. Placing it on the patient's chest gives you time to think what in hell you do next."

"I medically assisted a traveler with sleeping sickness flying from Tanzania to Amsterdam. I would do it again. I carry lots of medications, but not for all eventualities."

"In the Athens departure lounge a man in our group developed renal colic. To leave the area would have caused him to miss his flight. We scrounged enough opioids and other pain meds

Continued on page 3

Research Grants Available

The research committee fosters research in travel medicine, in keeping with the mission and goals of ISTM. The committee provides moderate grants (usually \$5000- \$10,000 maximum) designed to stimulate travel medicine research by supporting comprehensive research projects or, for larger projects, providing support for pilot studies, so that the investigator can apply to other agencies for more substantive research grants. For further details, please see the Research Committee report, page 4.

“Are You a Good Samaritan,” continued from page 2

from other travelers (including physicians) to keep him reasonably comfortable during the flight to the U.S.”

“I’m a nurse. I have done CPR on a plane, beach, subway platform, and in a city park. Unfortunately 2 of the 4 patients died, but in the hospital, not while I was assisting. I have stopped for road-side accidents, positioned patients, “prevented” inappropriate care of seizure patients, helped dehydrated travelers and escorted people to ERs (broken ankle, head laceration). I was never alone for long - other nurses and doctors responded - sometimes too many!”

“Flying from Milan to Madrid a lady had a panic attack but the steward thought she had a heart attack. I talked the lady down a bit and gave her diazepam from the aircraft’s medical kit. She was asleep when we arrived in Madrid. ...I may have prevented an unscheduled landing or other unnecessary actions by the crew. ...responding should be automatic for physicians. The intromission of government and business on physicians has damaged respect for physicians and has caused irreparable damage to the profession.”

“... In an airport, I was moved aside when paramedics arrived, which was fine. However, they misinterpreted the cardiac monitor and were going to shock a 3rd degree block until I helped them with the rhythm. They wouldn’t believe me until their ER-based doc confirmed my reading. Yes, I would do it again.”

“I pulled a passenger out of acute pulmonary edema at 3:30 AM over the South Pacific using nothing but 10 mg of furosemide, a single vial of digitalis, rotating tourniquets, and all the oxygen bottles aboard. As we landed I had to stand wedged between the rows of seats in front of him while holding him supine on the row of seats.”

“In flight, I had to provide proof of my MD credentials. Then I was offered a medical bag including a wide assortment of medications, including morphine. The passenger vomited on me. He turned out to be o.k. The flight attendant handed me a long form to complete, but did not offer to clean my clothes. I received a thank-you letter from the airline’s medical director. While I still believe we must assist I feel no obligation to complete forms for airlines for free, especially if they won’t even help me after being vomited on. Next time I help, I will write a detailed note and retain it for my records. But I will not provide it to the airlines for free. (I understand that

most airlines now offer appropriate recognition of a doctor’s help with either frequent flyer points or free tickets.”

“Most airlines now have links to emergency doctors on the ground. ... I was treating a lady in heart failure. The flight attendant placed the call. The line was continuously busy and we never got through. I did receive two free tickets to anywhere the airline flies in North America.”

“In Ethiopia I assisted at a road accident. I had an Advanced Life Support paramedics “jump bag.” I resuscitated a severely head injured patient; transported him on the back of our Toyota to the local hospital where there was no comprehension of managing an intubated patient. Did I do him a favour?”

“I am retired. I have assisted, and probably will continue to so. So far (fortunately for all concerned) I have encountered only air sickness and vaso-vagal reactions. If I thought it was something cardiac I’d tell the flight crew that I am retired and would encourage them to get advice from ER docs on the ground. I would help them by being the crew’s eyes, ears, and hands.”

“... Generally, I avoid dispensing medical care to guides, taxi drivers, etc. when traveling as a tourist. I try to avoid interfering with local care, even when it isn’t the best.”

“Many doctors are in specialties with little knowledge of emergency medicine. Is it a crime for them not to assist?”

“India rewards physicians with lower fares if they say that they will assist in emergencies...”

“...have assisted four or five times at airports/aircraft. Once found a man collapsed/cyanotic on the floor, having a seizure. I was able to open his airway until paramedics arrived. I almost missed my flight. Would the airline help if that occurred? (The victim was an attorney. He sent me a wonderful letter of thanks.)”

“... a passenger collapsed with a vaso-vagal episode. As I and another physician assisted him, we were essentially elbowed aside by four or five extraordinarily aggressive crew members who insisted that they knew best what to do. I’m glad he didn’t have something more serious.”

“I’m a nurse - and if there’s no doctor around, that’s who they yell for next. Calls I’ve responded to have been first-aid in nature, or stabilizing someone immediately post accident until EMS arrives. Have done CPR at accident scenes twice, in the early 70’s and mid-80’s. Did mouth to mouth each time...would I do it now? Not sure...”



**EDINBURGH
2006**

Edinburgh is the place to be in June, 2006 for a truly memorable travel medicine event. Ten travel medicine societies (yes, ten) are partnering to present a first class scientific program in the state-of-the art, award-winning conference centre located in the heart of beautiful and historic Edinburgh, Scotland, June 7-10.

ISTM Committee Reports



Message from the ISTM Secretary Treasurer

David Freedman, M.D.

I am pleased to report on our current financial status and on our budget plans for the coming year. A financial report for calendar 2004 was presented in Lisbon by my predecessor Frank von Sonnenburg and can be found elsewhere in this mailing.

On July 1, 2005 ISTM officially began its new fiscal year structure. A July to July structure allows robust budgeting and allocation in coordination with the annual Executive Board meeting which occurs each year in May or June.

Prior to my assuming the Secretary-Treasurer position this past May and implementing the new budgeting year, a complete audit of the ISTM books were carried out by Fulton, Kozak, LLP of Atlanta. ISTM received a clean bill of health. The figures presented at the membership assembly in Lisbon are the audited figures.

I am pleased to begin my term with ISTM finances in such excellent shape. I was able to take a role in negotiating the financial aspects of the ISTM's new 5-year publishing contract with Blackwell. This contract gives ISTM much more favorable terms than in the past and should end subsidies to the journal that ISTM had been providing. The money saved will provide funding for future ISTM initiatives.

Thanks to Frank von Sonnenburg, CISTM9 in Lisbon was the largest travel medicine meeting ever and the revenues should allow us to help loan advance funds to ISTM regional meetings held in non-CISTM years. ISTM membership is at record levels so membership income is also strong.

While Brenda Bagwell, our administrative director, will continue to process payments and receipts on a daily basis, we have engaged an outside accounting firm, Heritage Accounting, to provide and analyze monthly financial statements against budget and to assist in the annual budgeting process. Heritage serves solely non-profit organizations including membership organizations such as ISTM. All budget variances identified in the monthly reports need to be approved by the ISTM Finance Committee.

Our investments continue very conservative but with guaranteed steady income. Our reserves are mandated to be such that we could survive the complete failure of a CISTM meeting and continue operating through to the next meeting. We are well in excess of this amount.

A formal budget application process for ISTM committees and initiatives wanting funding for the year was begun this past spring, with the Executive Board the final arbiter of which activities will receive priority for funding. For 2005-6 significant funding was provided for the following committees:

- Membership - to continue to grow the membership,
- Development - to identify and solicit new sources of external funding in this time of decreased support from industry,
- Migration - to develop consensus documents and identify ways of incorporating those providers who serve the VFR population into the ISTM community.

Funds were also set aside to support the ISTM travel medicine research grant program, should no external contributions be available during the fiscal year.

I look forward to serving as your Secretary-Treasurer and I look forward to hearing from any member at istm@istm.org with any concerns or questions.

David

ISTM Research Committee

Anne McCarthy, Canada, Chair

2005 Grant Award Recipients

Congratulations to Daniel Uslan and William Stauffer, the principal investigators of the two winning research grants awarded by ISTM's Research Committee at CISTM9 in Lisbon. There were a total of 12 applicants for this competition. The review committee consisted of Irmgard Bauer (Australia), Pat Schlagenhauf (Switzerland), Annelies Wilder-Smith (Singapore) and Susan McLellan (USA). The funding was provided by generous support of GSK. The winning projects were:

1. *International travel and exposure risks in solid-organ transplant recipients.* PI Daniel Uslan, USA (\$9976);
2. *Prevalence of Malaria and evaluation of screening techniques for refugees arriving in the United States from West Africa.* William Stauffer, USA (\$8500).

In follow-up to the 2003 awards, all four awardees have completed their projects, and multiple abstracts from these projects were presented at CISTM9. We look forward to reading the published manuscripts.

The ISTM executive board supports an annual research competition. This year applications will be accepted from 31 October to 31 December. Winners will be announced in May, 2006. For further information, please look on the ISTM website under committees. A new grant application form will be available by the middle of October.

The ISTM research committee fosters research in travel medicine in keeping with the mission and goals of the society, including the promotion of international collaboration. The main research committee consists of nine members from four continents. Moderate grants (usually \$5000- \$10,000 maximum) are provided through a peer-reviewed comprehensive process. These grants are designed to stimulate travel medicine research by supporting comprehensive research projects or, for larger projects, providing support for pilot studies to enable researchers to collect data/tests hypotheses so that they can then apply to other agencies for more substantive research grants.

Award recipients are expected to provide updates to the committee chair every six months. The research project should be completed within two years of money receipt, and published within one year of project completion. All awardees are expected to present their data to the scientific community, and are encouraged to publish in *Journal of Travel Medicine*.

The winner of one of the Free Communications award at the Lisbon meeting, Tom Cumbo, was financially assisted in his research by ISTM. The abstract of his presentation appears on page 7.

Anne

Continued on page 5

“ISTM Committee Reports,” continued from page 4

Conflict of Interest Declaration (COID) for the Journal of Travel Medicine

Robert Steffen MD, Editor

The Journal of Travel Medicine (JTM) requires that all authors sign a declaration of conflicting interests. We will not reject papers simply because of conflicting interests, but we will declare the conflicts to the readership. A conflicting interest exists when professional judgment concerning a primary interest (such as patients' welfare or the validity or interpretation of research) may be influenced by a secondary interest (such as financial gain or personal rivalry). If conflicts of interest were revealed after an article was published, they might make a reasonable reader feel misled or deceived.

Authors should review all of the following items before concluding they have no conflicts of interest that are relevant to the manuscript being submitted for publication.

1) Acceptance in the past two years of any of the following from an organization that may in any way gain or lose financially from the results of your study or the conclusions of your paper:

- A fee for speaking
- A fee for writing this article
- A fee for organizing or chairing education
- Reimbursement for attending a symposium
- Funds for research
- Funds for a member of staff
- Fees for consulting and/or serving on an Advisory Board
- Patent royalties

2) Employment in the past five years by an organization that may in any way gain or lose financially from the results of your study or the conclusions of your paper.

3) Ownership of any stocks or shares in an organization that may, in any way, gain or lose financially from the results of your study or the conclusions of your paper.

4) Acting as an expert witness on the subject of your study or paper.

5) Any other financial, commercial, personal, political, or academic conflicts of interest.

We also require authors to disclose any research sponsorship that they received to conduct the study or prepare the manuscript or review. This information will be published together with the author affiliation information.

- Examples of acceptable statements are: “The study was carried out with support of an unrestricted educational grant from X” or “This study was funded in whole/in part by a grant from Y” or “XY has accepted fees for speaking from A and B and has served on an Advisory Board for C.”
- The role of the funding organization or sponsor in each of the following should be specified: design and conduct of the study; collection, management, analysis, and interpretation of the data; and preparation, review, or approval of the manuscript.

It is important that authors return this form as early as possible in the publication process. We will not publish articles without completion and return of the form.

Please tick one of the following boxes:

We have no interests to declare. Please print “No interest declared” with the article.

We have sponsorship and/or interests to declare.

- Research sponsorship was the following:
- Please print the following statement on possible authors' interest with the article:
- Research sponsors contribution was the following:

The corresponding author guarantees the integrity of the data and its analysis. Persons having a major part in manuscript preparation are acknowledged.

Signature (s) _____

Date _____

Robert

Report of the ISTM Migration Health Sub-Committee

Brian Gushulak, MD, Co-Chairman
Louis C. Loutan MD, Co-Chairman

The opportunities and potential benefits to the International Society of Travel Medicine related to the health and medical issues of non-traditional international travelers, such as immigrants, refugees and asylum seekers (“migrants”) have been the subject of discussion at the level of the Executive Committee for some time.

Interest in this area has been supported by a number of factors:

- *In many locations migrants represent the cohort of international travelers with the greatest incidence and prevalence of what is generally considered travel related diseases - malaria, parasitic disease, and tropical infectious disease, for example.*
- *Migrants often represent the major or significant case loads of practitioners who deal with tropical medicine or imported infections in the developed world.*
- *Migrants living in industrialized countries who travel to visit friends and relatives in their country of origin represent an increasingly important travel medicine risk group.*
- *Increasing migration from developing countries to industrialized countries, particularly those in Europe, Asia and the Middle East, is expanding the number of physicians and health care providers involved with the care of these populations.*
- *At the present time there is no generally recognized group or organization that deals in an integrated manner with the travel health issues of migrants in the international context.*

These factors have provided and continue to provide the perception of opportunity for the ISTM in terms of organizing standard approaches to the issues, creating useful links and networks for those involved, and sharing knowledge gained by those who deal with migrant travelers. As the appreciation and study of the health of migrants has grown over the past decade, positioning the Society to capitalize on these opportunities has been a desired goal of some members of the Executive Committee.

Work to Date

Effectively capitalizing on these opportunities to the benefit of the ISTM has been a goal since the mid-1990s. The results of these efforts have not been dramatically rewarding. The issue remains of direct interest to some members of the Society but the Committee has been ineffective in generating wide interest in the issue within the ISTM as a whole.

The general strategy that has been used by the Society over the past few years has been one of trying to build the appreciation of the potential opportunities provided by the issues of migration health within the general society membership. This ‘build it and they will want it’ approach has not been particularly effective and, in retrospect, that is probably not

Continued on page 6

“ISTM Committee Reports,” continued from page 5

surprising. Given the current demographic makeup and practice patterns of the Society’s membership, there are probably few members not already involved with migrants who are likely to become so. Attracting new interest from within the ISTM will be limited to some specific issues, not the area of migration and refugee health in general.

The difficulties in promoting a cause or an idea in an organizational context where the general appreciation of the cause is low are significant and, for some of the promoters, can be demoralizing. While some members of the Committee on Migration have extensive experience in the area, others are newly facing the challenges posed by migrants in their particular locations, hospitals and clinics, and are there to learn. This creates a situation where much Committee action is directed at repetitively redefining the issue, explaining relevance and linkages, and identifying areas of potential study for Committee members.

The outcome is that the Committee often becomes a focus group for those few with common interest who end up at the Society’s events. While useful for a few, the ‘focus group’ nature of the Committee functions impedes the production of documents and tools of broader interest. At the same time, ‘committee work’ is, in reality, a strategic task for the organization that is not actually ‘committee’ activity.

The current committee model as used for other ISTM committees is, in retrospect, probably inappropriate for the desired task. Strategic direction in organizations is only rarely provided by committee. Committees are important in the delivery of product in the strategic context but are singularly ineffective in the development of strategic guidance. That must come from the organization executive who must champion the issues and defend and support the efforts. As the migration and refugee health issue is not a current mainstream activity for the society, the focus of those involved in its further development will have to change. The executive may have to consider a ‘working group’ or ‘task force’ model where those involved are more responsible to the organization’s management as opposed to the committee membership.

Examples of Potential Utility for the ISTM

Specific issues, however, such as VFR (visiting friends and relatives) do have the potential to directly impact on the broader membership of the Society and it is here that internal focus may be productive.

The experience with VFR travel as an issue provides a positive example of this effort. Migration Health Committee members produced a short publication, *The Migrant as Traveler? – Visiting Friends and Relatives*, for NewsShare in March/April of 2002. At that time, a MedLine search of the term “VFR Travel” found no peer-reviewed citations. A similar MedLine search conducted on January 25, 2005 discloses three citations dealing with the issue, all by Society members.

- Angell SY, Cetron MS. Health disparities among travelers visiting friends and relatives abroad. *Ann Intern Med.* 2005;142:67-72.
- Bacaner N, Stauffer B, Boulware DR, Walker PF, Keystone JS. Travel medicine considerations for North American immigrants visiting friends and relatives. *JAMA.* 2004;291:2856-2864.
- Loutan L. Malaria: still a threat to travelers. *Int J Antimicrobe Agents.* 2003;21:158-163.

While none of the authors cite the NewsShare article directly, and in spite of the fact that two of the three publications are authored by members of the Migration Sub-Committee, the topic does provide an example of how some specific, migration-associated issues can be relevant in the broader travel medicine context.

Where Do We Go from Here?

At the strategic planning meeting for the Society in December 2004, the potential benefits to the ISTM related to the issues of migration and refugee health were again the subject of debate and discussion. The Executive of the Society remains, with some exceptions, committed to the issue. A Charter for the Committee was drafted and presented:

- The Migrant and Refugee Health Committee is responsible for developing the area of Migrant and Refugee Health as an area of strategic investment for the ISTM.
- The Migrant and Refugee Health Committee is charged with developing and proposing initiatives to increase the membership of Migrant and Refugee Health practitioners within the ISTM.
- The Migrant and Refugee Health Committee is charged with proposing specific programs or initiatives to serve the interest of migrant and refugee health.

Brian and Louis

Publications Committee Report

Charles D. Ericsson, MD, Chair

In September the Executive Board approved the Publications Committee’s final iteration of the plan to develop evidence bases for clinical practice. A Task Force will be composed of two members from the Publications, *JTM*, Professional Education, Exam, Practice, and Nursing Issues Committees. This task force will be assigned to come up with 1-2 topics per year for the development of evidence bases to be published in *JTM*. “Evidence Bases for Clinical Practice” by any other name is clinical guidelines, but the consensus was not to use the title “clinical guidelines” since there are too many differences in actual practice around the world and the Board wanted to avoid any political or legal implications of having “guidelines”.

If anyone in the membership has an idea about a topic that they wish to be developed into an evidence base please forward the idea to Dr. Ericsson at charles.d.ericsson@uth.tmc.edu. When topics have been decided, the membership will be notified and will be given the opportunity to volunteer to be on the writing panel for that topic with the understanding that the final constitution of the writing panel will be decided by the task force and the Executive Board based on expertise and geographic representation.

The Board has approved a new face for *JTM* for when Blackwell takes over at the beginning of 2006. The new cover is much more modern and fresh in appearance.

The Board has agreed to consider in more detail a proposal to publish our meeting abstracts in *JTM* as a standalone supplement. This is a complex issue that might imply additional fixed cost to ISTM. The scientific committee and editor will need to decide which abstracts, if not all, are publication-worthy, since some abstracts are accepted to encourage participation and development of our discipline rather than because of solid scientific value. The finance committee will explore whether additional costs can be defrayed by new funding sources. The Board will need eventually to decide whether any additional costs of publishing abstracts might be outweighed by an anticipated increase in our journal impact factor. A final decision on publishing our abstracts in *JTM* awaits resolution of these thorny issues.

Charlie

Continued on page 7

"ISTM Committee Reports," continued from page 6

Membership Committee

Bradley A. Connor, Chair

The ISTM leadership has identified growth in membership as a strategic priority of the Society. We have therefore launched a Membership Committee responsible for developing and deploying strategies to increase our membership in all geographic areas, and I have agreed to lead this effort.

Growth in membership has leveled off at about 5% per year. While this growth is a positive reflection on the Society, we can do much better. To become an even more influential global entity, we need to expand our membership. More members help provide additional resources for important Society initiatives.

If we intend to have influence in the developing world, we need to develop membership in developing countries. If we intend to address the issues of Migrant and Refugee Health, we need to expand our membership in the Migrant and Refugee Health community. If we intend to maintain our positions and influence in Europe and North America, we need to maintain and grow our membership in these areas.

Over the past several years the ISTM has placed little effort into membership growth. However, we have reached a size and scope as a Society where membership growth needs to be proactive rather than a byproduct of our other activities. Developing, organizing and implementing a membership outreach program is a challenge which requires effort, thoughtfulness and resources. Therefore, I have agreed to chair this Committee over the next two years: to reestablish the committee, set its direction and implement strategies and processes which will grow the society into the future.

In order to meet these challenges the Committee needs representation from every part of the world. One of my near term priorities is to identify and name regional associate chairs of the Committee.

To anyone with ideas for reaching out to new members in your communities, I am open to your ideas. I encourage you to join me. Please get out the word about the ISTM to your professional contacts and colleagues.

Brad

Award Winning Presentations at CISTM9, Lisbon

Innumerable individuals spend much time and energy in making ISTM meetings so successful and do not get the recognition that they deserve. Therefore, we print the abstracts of some of the award winners for outstanding presentations. Here are two abstracts of the Free Communications award winners.

Higher Venous Levels of Bicarbonate Anion Concentration are Associated with Excessive Hypoxemia in Lowland Dwellers Ascending to Moderate Altitude (4250m) *Cumbo T.¹, Braude D.², Basnyat B.³, Shah M.², Radder D.⁴, Bashyal G.⁴, Gambert S.¹, Rabinowitz L.², Lescano A.⁵*

¹Johns Hopkins University / Sinai Hospital Internal Medicine Program, Medicine, Baltimore, Maryland, ²University of New Mexico School of Medicine, Emergency Medicine, Albuquerque, New Mexico, ³Nepal International Clinic, Kathmandu, Nepal, ⁴Himalayan Rescue Association, Kathmandu, Nepal, ⁵Johns Hopkins University School of Public Health, Baltimore, Maryland

Objectives: To determine the relationship between hypoxemia and venous bicarbonate anion concentration in lowland dwellers ascending to moderate altitude.

Background: Little is known concerning the relationship between excessive hypoxemia and acid-base balance at altitude. Our group had previously noted a strong association between decreased urinary base excretion, decreased intravascular volume, acute mountain sickness (AMS) and hypoxemia in a large cohort of lowland dwelling pilgrims making an ascent to approximately 4250 meters in the Langtang region of the Nepal Himalayas. To further investigate the hypothesis that base retention is associated with lower oxygen saturation at altitude, we returned one year later to obtain more precise serologic measures of alkalosis. Our expeditions occurred during an annual Hindu festival in Honor of the Vedic Deity Shiva (Janai Purnima). Each year thousands of individuals ascend from approximately 2000 meters to 4250 meters in 1-3 days. This rapid ascent has as its final destination Lake Gosainkunda, located north of Kathmandu and approximately 20 kilometers south of the Tibetan border. Ill pilgrims frequently develop marked hypoxemia and commonly exhibit arterial oxygen saturation (SaO₂) levels lower than 75%.

Is there a Long-Term Persistence of Malaria Immune Memory in African Migrants Living in France for Years? *Bouchaud O.¹, Genty S.¹, Ralaimazava P.¹, Cha O.¹, Matheron S.², Leclerc D.¹, Heller M.¹, Pole Nord Tropical G.³*

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Objectives and Background: (fixed font)

In population living in areas endemic for malaria, repeated parasite exposure allows protective immunity to the disease to progressively rise. However, it is usually considered that, several years after termination of exposure, this acquired immunity vanishes. The aim of this study was to investigate this point by comparing the features of malaria attacks in Europeans and in African immigrants, resident in Europe for several years.

Material and Methods: (fixed font and spacing)

We performed a prospective study with uni- and multivariate analyses of 252 African immigrants resident in Europe for at least 4 years, and 99 European patients presenting at our institution with a *Plasmodium falciparum* (Pf) malaria attack after a short-term trip in sub-Saharan Africa (<3 months). Clinical and biological features of their disease and Pf antibody level (measured by immunofluorescence 10 to 12 days after onset of symptoms) were collected for patients of each group.

Results: (fixed font and spacing)

Both Africans and Europeans were comparable in age and sex-ratio and were generally infected in west or central Africa (most frequently Cameroon or Côte d'Ivoire). Patients originating from Africa (median length of residence in France of 14 years [4-45]) exhibited reduced mean \pm SD parasite densities (0.8 \pm 1.5/100 red blood cells versus 1.4 \pm 2.8/100 red blood cells, $p=0.007$), less frequent severe disease (4.4% versus 15.2%, $p=0.0005$), and an accelerated parasite and fever clearance mean \pm SD times following treatment (respectively, 55 \pm 24 hours versus 62 \pm 30 h, $p=0.03$, and 40 \pm 25 h versus 56 \pm 31 h, $p<0.0001$), when compared to the European patients. In addition, their Pf antibody levels were higher (77.3% of Africans had reciprocal titers of 256 or more, compared to only 52.4% of Europeans ; $p=0.0003$).

Conclusions: Our results suggest a persistence of acquired immunity among patients originating from Africa, even after several years in non-endemic area. However, given the persistence of the risk of malaria and, in some cases, of a severe disease, prevention counseling should remain vigilant and be improved.

"The President's Column," cont. from p. 2

during our non CISTM year. There are many exciting topics from emerging infections to health risks in the Northern Europe and the Baltic region.

CISTM 10 will be held in Vancouver May 20 - 24, 2007. The Scientific committee and the local organizing committee are already galvanized into action to bring to you the best ISTM conference ever.

The relevance of our specialty continues to grow. This is a most important time to promote membership to your friends and colleagues. I look for suggestions from you as we move forward in a mutually beneficial relationship. Please help spread the word about the benefits of ISTM membership, the ISTM certificate of knowledge examination (CTH) and the very popular ISTM sponsored conferences.

I hope to see you in person in Edinburgh and in Vancouver. Please see the Calendar for further details.

With warm regards.

Prativa

NewsShare

the Quarterly Newsletter of the International Society of Travel Medicine

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