



ISTM News

Report from the Publications Committee

Following the *Journal of Travel Medicine (JTM)* strategic planning meeting in Helsinki, an extensive action plan was developed regarding the JTM. Many of the goals of the plan have already been realized and others are still in progress. In addition to the goals outlined below, *JTM* has already successfully instituted page charges to be applied to lengthy articles. This will not only encourage succinct manuscripts but will also support a major objective of the Executive Board; namely, that *JTM* strive to be cost neutral to our society.

Goals arising from the strategic planning meeting include:

1. Decrease journal's backlog by publishing more articles in a couple of upcoming issues and discouraging lengthy papers for future publication.
2. Reduce journal's time to publication by introducing new workflows and efficiencies in the peer-review and production systems.
3. Implement strategies to increase citations to journal.
4. Investigate potential for translations of journal or selections of journal into other languages.

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Should Travel Medicine Practitioners Sell Health-Related Travel Products and Services to Their Travel Clients?

As readers of NewsShare know, several times a year we ask your opinion about a subject of interest to travel medicine practitioners. This time our questions were:

- What are your thoughts regarding travel medicine practitioners selling health-related travel products and services to their travel clients?
- Do you provide such products and services? If not, why not?
- Are there conflicts of interest in doing so?
- Are you aware of restrictions on such practices in your jurisdiction?



Our survey reveals that the clinics that responded provide one or more of the following services:

- Sell mosquito netting, mosquito repellents, travel health manuals, and first aid kits. (These are by far the most common items sold.)
- Sell anti-malarials, antibiotics and other prescription drugs.
- Sell sun protection products and numerous other items more distantly related to travel medicine.
- Sell travel-related insurance. Some clinics receive commissions for doing so, others merely hand out literature from several insurance companies.
- Distribute catalogs of companies that provide travel-related products. Some clinics receive commissions, others do not.

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The Practice and Nursing Issues Committee

An Invitation to Nurses Attending CISTM I I in Budapest!

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



- Meet and greet colleagues from around the world
- Hear about conference highlights
- Network with nurse colleagues in an informal and interactive setting (remember to bring your business cards!)
- Exchange information and contact details
- Enjoy refreshments

Date: Sunday 24 May (prior to CISTM11 Opening Ceremony)

Time: 14:45-16:45hrs (2:45 pm-4:45 pm)

Place: Harmony Hall ELTE University Congress Centre
Pázmány Péter sétány 1/a, 1/c, H-1117 Budapest, Hungary

Information and directions will be provided in registration bags on-site and posted at the registration desk. See www.istm.org for programme information.

— “*ISTM News*,” cont. from p. 1 —

5. Promote *JTM* as member benefit of *ISTM*.
6. Ensure that relevant databases have appropriate keywords to identify *JTM* articles.
7. Develop marketing promotions that will draw attention to *JTM* and *ISTM* and promote citation.
8. Forge relationships with national societies.
9. Attract new members by targeting specific professional constituencies.
10. Build up advertising sales program by diversifying advertisers.
11. Develop supplements program.
12. Pursue possibility of journal-based CME/CE program.
13. Research potential for sponsored subscription program.
14. Maintain *JTM*'s high standards for publication ethics.

ISTM encourages all authors and *ISTM* members to continue to support their journal as the premiere location for travel medicine related manuscripts. If any member has suggestions about how *ISTM* can improve the value of its journal, web page or NewsShare, please contact Charlie Ericsson at charles.d.ericsson@uth.tmc.edu.

Respectfully submitted,

Charles D. Ericsson, M.D.
Chair, Publications Committee



— “*Should Travel Medicine Practitioners Sell Health-Related Travel Products*,” cont. from p. 1 —

• Obtain visas and take passport photos.
We received 65 responses. Here are some representative views.

- For many years I was reluctant to sell products at our clinic. But insect repellents were difficult to find in Canada in the winter so I ended up offering them. Bed nets made sense, too. Slowly, we increased the number of items to include first aid kits, needle kits, and hand sanitizers. With more travelers coming in at the last minute - sometimes with luggage in hand - selling products may make the difference between traveling with or without such resources. As we also care for long-term travelers (working abroad), both their employers and the travelers themselves appreciate being able to purchase items we recommend rather than searching for them on the web - and worrying that the items won't reach them by departure time.
- We are a large, private travel medicine clinic in Brazil. We need government authorization to practice. We provide pre- and post-travel consultations and all vaccines, and we sell many travel-related products. We do not provide insurance or visas. And anti-malarial drugs can only be acquired through governmental services.
- I work at a U.S. Navy healthcare facility. In-office sales of products are prohibited. But I have thought about this topic for some time.

There are obvious conflicts of interest. Anticipating these and drawing clear boundaries around what is acceptable vs. unacceptable practice is an important exercise, one that an organization such as *ISTM* should embark upon. In many ways this is similar to the situation that arose in the U.S. (and probably elsewhere) concerning diagnostic radiologists owning their own CT and/or MRI scanners. Their clinical practices and recommendations for further imaging were clearly swayed by the fact that they stood to gain financially from their recommendations. The federal government got involved, mainly because there were serious dollars and reimbursement issues that the U.S. Government had a stake in.

The fact that we cannot sell products does not prohibit us from recommending certain ones or categories, and recommending retail outlets where such items are sold. I believe this is the optimal solution. The convenience argument is always enticing,



photo taken from www.newblinds.co.uk

but once practitioners start marketing products in their offices, the door opens to ‘detail guys’ - just as in the pharmaceutical field, with marketers looking to influence the practitioners’ habits (in this case, what items are stocked and at what prices they are sold).

- In Belgium, it is illegal to sell products and services - from bed nets to insurance.
- Our travel clinic (U.K.) is part of a charitable foundation, one that provides blood transfusion-related products for travellers. Charitable foundations cannot sell products. We do, however, provide transfusion-related items and immunizations at reduced fees through a related enterprise. We would not be allowed to sell any form of insurance unless we were registered with the Financial Services Agency and had staff with the required qualifications.
- We are a physician-run, hospital-based practice (U.S). The amount of time, energy, and resources (including costs of attorneys to research the issue) is not worth the amount of money that could be generated from selling products. I recommend places where travelers can obtain items. ... I do not want travelers to think that I have a conflict of interest.
- We are a “one stop shop,” convenient for the traveler who often comes in at the last minute and has given no thought to items one might need/want. We do carry medica-

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“Should Travel Medicine Practitioners Sell Health-Related Travel Products,” *cont. from p. 2*

- tions in-house for corporate travelers and those leaving on short notice. I see no conflict of interest. In our state (U.S., state unknown), we must have a sales tax identification number and an MD dispensing license.
- I see no conflicts. The issues are the same as if you advise vaccines and supply the vaccinations. A reasonable markup, one that is competitive, adds value for the client you are serving. In our Canadian province I am not aware of any restrictions on what we are doing.
 - We do provide a wide variety of travel-related products for sale, including electric converters, hats and scarves, and sunglasses. We began offering these when our clients kept saying that they could not find them elsewhere or had to travel far to obtain them. Permethrin-treated netting is available only through one company in Canada; retailers do not stock them. We collect and pay appropriate sales taxes. Doctors' offices can't compete with regular outfitters in most areas so we must be more efficient in what we do sell. A clinic needs to be well organized to do the medical part. The added retail chores may be too much for some. I do know one place that offers travel immunizations, and advocates sun tanning beds. Clearly they have gone too far.
 - In the French speaking part of Switzerland, doctors are not allowed to sell medication (except vaccines and some other injectables) or other travel-related items.
 - We add expertise to the travelers' purchases. In stores, travelers are overwhelmed by competing products and must decide for themselves which is the best for their trip, state of health and children, for example. We make recommendations solely based on the quality of the products we sell.
 - We distribute catalogs and have a list of companies that provide insurance. We have no affiliation with the companies. Prescriptions are sent to the patient's pharmacy. I am not aware of any restrictions in Texas on selling items other than pharmaceuticals.
 - I used to sell repellents to assure that travelers obtained the right product. I stopped because our clients (U.S.) had “sticker shock” when they got the bill and it was not covered by insurance. And my profit was slim.

- Our patients appreciate the convenience of being able to buy products from us and the fact that the products we offer are the best available. Also, our display reminds them of the necessity of the items, even if they don't buy them from us. The small profit helps keep the clinic going. We stock the usual products, assemble our own first-aid kits and take digital passport photos. As a result we are known as a travel center and this encourages referrals. Travel insurance is different. We refer patients to insurance sellers. Selling insurance (and receiving commissions) could make us less objective about the services we provide.
- I do not sell any products. Don't have the time. Pharmacists stock the items. I write

the prescriptions. Travel agents obtain the visas, etc.

- When I inform patients about the items we sell, I also tell them where else they can purchase them. But being able to show the products makes it clearer to them what I am talking about. We do NOT provide evacuation insurance but strongly recommend it. Some insurance companies have offered us a percentage of the profits for recommending their product, but that seems unethical. We include a DAN (Diver's Alert Network) brochure in our handouts.
- All of our clinics are located in general travel stores selling various items. The

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The Way it Was Women, Travel and Expeditions - 1850

Never hastily refuse the pleas of women to join expeditions. There are few greater popular errors than the idea, mainly derived from chivalrous times, that woman is a weakly creature. In the days of baronial castles, when crowds of people herded together within the narrow enclosures of a fortification, and the ladies did nothing but needlework in their boudoirs, the mode of life was very prejudicial to their nervous system and muscular powers.

The women suffered from the effects of ill ventilation and bad drainage and had none of the counteracting advantages of military life that was led by the males. Consequently, women really became the helpless dolls that they were considered to be and which is still the fashion to consider them.

A hard-working woman is better and happier for her work. It is the nature of women to be fond of carrying weights: you may see them in carriages, always preferring to hold their baskets or their babies on their knees, to setting them down on the seats to their sides. A woman, whose modern dress includes no one knows how many cubic feet of space, has hardly ever pockets of sufficient size to carry small articles; for she prefers to load her hands with a bag or other weighty subjects. A nursery-maid, who is on the move all day, seems the happiest specimen of her sex.

And on expeditions, native wives are of great service and cause no delay; for the body of a caravan travels at a foot's pace, and a woman will endure a long journey nearly as well as a man. They are invaluable in picking up and retelling information and hearsay gossip which gives clues to much of importance, that, unassisted, one might miss. Also, when men, are too heavy laden they can neither hunt nor travel any considerable distance, and if they meet any success in hunting, who is to carry the produce of the labour? Women were made for labour: one of them can carry or haul as much as two men can do. They also pitch tents and make and mend clothing. Though women do everything, they are maintained at a trifling expense; for, as they always stand to cook, the very licking of their fingers in scarce time is sufficient for their subsistence.

...from Francis Galton's *Art of Travel*, 1872. Reprinted by David & Charles, Devon U.K. 1972

*“Should Travel Medicine Practitioners Sell Health-Related Travel Products,”
cont. from p. 3*

nurses can legally sell prescription medicines under the UK Patient Group Directions. I do not think that there are conflicts of interest.

- We save travellers money by charging less for items than do other sources. (UK).
- We do sell products. Where I live in Australia, access to travel-related products is otherwise difficult. Selling products also increases my profits and improves the perceived quality of the comprehensive travel health service I provide. I am careful to avoid conflicts of interest. I don't want to be seen as just selling stuff so I tend to be fairly conservative in my recommendations - perhaps this is a problem in itself. I am not aware of any restrictions in selling these items. We provide a small range of products: nets/repellents/medical kit, anti-malarials and loperamide. I see no conflicts because the items we recommend are available locally. The difference is that our products can be discussed with a specialist. The advice we give is on information sheets to all travellers and many choose to get the products elsewhere, usually the Internet.
- We don't sell products. We have discussed it among the staff, but our problem is one of space. Another travel clinic in town is all about products, including filling prescriptions. Their reputation is “shot shop” - all products, no information, no follow-up. If we did sell products, I would have some concerns about conflict of interest. When we recommend products it is not because we sell them.
- We do not provide products. I would consider promotion of branded products to be a conflict of interest with the UK NHS ethos, though I am aware that some practices do offer products at their clinics. If we did, it would be difficult. I work in a general practice, with limited space to store, and with no facilities for payment other than cash/cheque. Also, many of the products would be outside the knowledge and competence of some of my colleagues to advise upon or recommend. I am the ‘travel health specialist nurse’ in the practice but I am only available 2 days each week. What happens when I am not there? I trust my colleagues to risk assess and advise about travel issues within their competence and with access to accredited resources. Things like first aid kits should be individually put together based on individual needs.

An Old Enemy Returns: Cholera

Excerpted from the Bulletin of the WHO



The recent cholera outbreak in Zimbabwe is not only symptomatic of the breakdown of water and sanitation infrastructure, but also of the restricted availability of a simple life-saving treatment – oral rehydration salts (ORS) solution. While little can be done in the short term to improve access to safe water and appropriate sanitation in countries like Zimbabwe, much could be done to improve the availability of ORS solution for treating diarrheal diseases.

In early January, 600 new cases of cholera were being reported daily in Zimbabwe with 5-8% of victims dying. Nearly half of those deaths occurred at home. According to WHO's Global Task Force on Cholera Control, a possible 80% of those afflicted could have been treated successfully with oral rehydration therapy – by people with no medical knowledge – which could prevent most deaths.

ORS solution was formally endorsed by the WHO in 1978 and is credited with preventing an estimated 40 million deaths. It can be used at the household level while people are waiting to access proper health care.

But the Zimbabwe government decided to promote self-medication with homemade solutions of sugar and salt. Unfortunately the epidemic struck at a time when most Zimbabweans are unable to purchase sugar and salt. The absence of such basics is symptomatic of a broader collapse. There are few cholera treatment centers, and people can't afford to travel or are too sick to catch a bus to travel there. Hospitals are empty; water and sanitation are poor.

But this year the situation may start to improve. In early December 2008, WHO advised the Ministry of Health and Child Welfare in Zimbabwe to endorse the administration of ORS solution by people with no health-care training to treat diarrhea in the home in line with WHO policy. In conjunction with the Ministry, WHO has now established a Cholera Command and Control Centre, with a team of epidemiologists, logisticians, water and sanitation experts, and health workers, with the aim of executing a coordinated response.

Zimbabwe's initial reluctance to mount an effective response early on, or even to admit that an outbreak was occurring, is not unique. Countries often fear their tourism and trade will be affected. They are scared of stigmatization.

WHO estimates that about 120,000 people died of cholera worldwide in 2007, while millions more were infected, numbers that are in stark contrast to official figures that countries report to WHO. The official numbers reported [for that year] to WHO were 4031 deaths and 178,000 cases. Underreporting is the norm not only for cholera but also for other diseases,

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— "Cholera," cont. from p. 4 —

including typhoid fever, shigellosis, leishmaniasis and yaws.

Cholera-like diseases have been described in the ancient Chinese, Greek and Sanskrit literature. Since the 19th century, cholera has been particularly associated with the fertile Ganges river delta, with its labyrinth of waterways and swamps. Seven cholera pandemics have sent waves of the disease across the world since the 1800s.

The communities that have suffered the most from the devastating effects of this disease treat it like a fact of life and, even where simple affordable treatment is available, the illness carries an immense stigma. People don't want to talk about it. They think it's normal to have diarrhea. Quite often, nobody is interested in providing the minimal support needed for prevention.

One of Europe's worst cholera years on record was 1854, when 23,000 people died in Great Britain and Ireland alone. That was also the year that English physician John Snow first demonstrated the link between contaminated water supplies and the spread of cholera. Another milestone in the fight against cholera came in 1883, when German physician Robert Koch isolated *Vibrio cholerae*, the causative organism, while studying outbreaks of the disease in Egypt and India.

Despite the fact that ORS solution is an effective treatment for dehydration from the disease and despite the existence of a cholera vaccine – albeit an unsatisfactory one due to its two-dose regimen, short shelf-life, high cost and need for cold chain distribution [and limited effectiveness, Editor, NewsShare] – prevention must be at the heart of any effective long-term response. There is an urgent need to provide a programmatic, concerted and coordinated approach to cholera control. Prevention, preparedness and response activities together with an efficient surveillance system are paramount.

The approach to cholera outbreaks in many developing countries has been that of reactive response directed at controlling outbreaks and minimizing mortality. Little or no proactive measures are taken to prevent the disease.

Prevention is, for the most part, a question of ensuring hygiene. The front line with cholera is the village latrine and drinking water supply. Referring to improvements in drinking water and sanitation in the mid-19th century in Europe after Snow's discovery, the last chol-

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Disasters: Their Effect on Tourism

How long does it take tourism to recover when earthquakes, tsunamis, terrorism and floods devastate a popular international tourist destination?

Surveys show that, generally, recovery is far more rapid than most people think. In fact, the numbers of visitors often and quickly rise to numbers greater than before the event, says the Paris-based *International Herald-Tribune*. And, frequently, the disaster site itself becomes a tourist attraction, further adding to the numbers of visitors. Disasters seem to bear out the old adage that any publicity is good publicity, says the newspaper.

"Disaster tourism" is an old term that is becoming more frequently used – perhaps, in part, because disasters are becoming more frequent. It is a topic of discussion in scholarly travel industry journals, at postgraduate seminars on travel at universities, and at conferences where travel is presented as a subheading in sociology and psychology. (Most travel medicine practitioners are not familiar with this huge existing discipline of learning, a discipline somewhat related to the field of travel medicine. NewsShare plans some articles about this in upcoming issues.)

A case study on disaster/travel frequently cited is the October 2002 bombings in Bali that killed 202 people. These bombings were specifically targeted to kill as many Western tourists as possible. After that event visitor arrivals plunged to 993,000 for the year after the bombing, but bounced back to 1.46 million in 2004, a level higher than the two years before the bomb, according to the Pacific Asia Travel Association. Moreover, even among Australians, who suffered the worst casualties in the bombing, the number of visitors to the Island bounced back within two years.

The recovery of Bali is even more impressive in face of continuing threats from Islamic extremism in the area, a subsequent bombing that killed 20 tourists in 2005, a few natural disasters, outbreaks of bird flu disease, and lax safety standards in the country which, among other measures, have resulted in the sinking of crowded ferry boats and the banning of the Indonesian national airline from operating in Europe. Yet in 2007, Bali man-



aged to surpass its foreign tourist arrival records for the second year in a row. In late 2008, the thousands of hotels, which only several years ago were left eerily vacant, are reporting capacity of more than 90 percent. Throngs of tourists, led by Japan, Australia and the United States, now flood the streets and the shops.

Another case study is the rapid return of travelers to Thailand after the Tsunami disaster in 2006, an event that killed perhaps two hundred thousand people. More than 500 Swedes died on the Thai resort island of Phuket, the largest number of deaths of any foreign nationality. Nevertheless, Swedes were soon returning to the island in larger numbers than before the disaster, according to travel professionals in Sweden.

Disaster tourism took hold in the Greater New Orleans area in the aftermath of Hurricane Katrina. Before the waters had fully receded there were guided bus tours to neighborhoods that were severely damaged by storm-related flooding. Some local residents have criticized these tours as unethical, because the tour companies were profiting from the misery of their communities and families. The U.S. Army Corps of Engineers noted that traffic from tour buses and other tourist vehicles interfered with the movement of trucks and other cleanup equipment on single-lane residential roads. Furthermore, during the first six months after the storm, most of these neighborhoods lacked electricity, phone access, street signs, or access to emergency medical or police assistance. Simply traveling to these neighborhoods was hazardous. For these reasons, organized disaster tours were banned from two of the most severely damaged areas in the city. But other neighborhoods welcomed such tours as a means to publicize the scale of the destruction and attract more aid for their area.

Medical Tourism: Implications for Travel Medicine Providers

“We in travel medicine have an obligation to address queries forthrightly as a service to our patients.”

Travel medicine providers need to be informed about the issues of medical tourism and, especially one of its more ‘dark side’ offshoots: stem cell tourism, the new snake oil of the 21st century.

The Internet is full of advertisements for medical tourism companies. Clinics in Asia, Latin America, and Europe promote ‘miracle cures’ for heart problems, diabetes, Parkinson’s disease, anterior lateral sclerosis, muscular dystrophy, and a variety of other conditions. Treatments often cost between \$20,000 and \$25,000 U.S., and sometimes more! Vulnerable and desperate people are flocking to these clinics.

We in travel medicine have an obligation to address queries forthrightly as a service to our patients. Because the field of medical tourism is progressing at lightning speed, this will be challenging. I receive daily Google alerts on ‘stem cell research’ and ‘stem cell therapy.’ These are full of various opinions and testimonials, along with some interesting scientific information. A critical eye is needed!

Bangkok has become a major hub for medical tourism. I recently spent ten days there as a visiting professor at the Chulalongkorn University Medical School. I was invited by the faculty to discuss and review primary care in

Thailand, the impact/quality of medical tourism, and the risks associated with expensive health care practices - copied from the USA. I had been to Thailand several times previously so I had some familiarity with local conditions.

During my time there, I visited several of the ‘5-star’ hospitals. They have many Western-trained physicians on their staffs and state-of-the-art equipment, PET-CTs and MRIs, for example. Yet one of the hospitals specializing in cardiology is also doing stem cell cardiac therapy (yet to be proven effective by proper trials).

Prior to 2001, hospital quality improvement programs had not yet been fully implemented in Thailand, but the need to reassure medical tourists and other international patients about safety and quality of care was a principal factor in the rapid drive to certification. Also, if Bangkok was to become a major hub for medical tourism, authorities had to compete on the global stage. While their efforts are admirable, there have been some growing pains in regard to communication between surveyors and health professionals (Pongpuril et al. *International Journal of Quality in Health Care*, 2006;18(5):346-351).

The major Bangkok hospitals are Joint Commission International (JCI)-certified since about 2001/2002. The JCI is a subsidiary of the Joint Commission on the Accreditation of Healthcare Organizations* (JCAHO) in the U.S. - with which we, in the U.S., are all too familiar! Recently, the World Health Organization (WHO) has designated JCAHO and JCI as the world’s first WHO Collaborating Centre dedicated solely to patient safety (www.ccforspatientsafety.org). This gives major Bangkok hospitals a greater level of credibility, in many cases deservedly so.

However, medical practice is not as tightly regulated in Thailand as in most Western countries, so one must be careful in seeking care there, especially for treatments such as ‘chelation therapy,’ which has long been discredited in most Western countries, and stem cell therapy. The International Society for Stem Cell Research (ISSCR) has published guidelines for researchers and clinicians and a handbook for patients, which can be downloaded for distribution. (See www.isscr.org for patient handbook and provider/researcher guidelines published in December 2008.) Of course,

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besides the concerns about the treatments themselves, there are many other issues required for optimum care, follow-up at home, and dealing with complications, for example. Also, one Bangkok hospital has about 1000 doctors on staff, so knowing who will do your treatments/operations is important, just like it is in other countries.

Thailand has made exemplary strides in public health, such as reductions in infant mortality. Also the number of rabies deaths has declined from about 400 annually in the 1980’s to about 20 in 2008. This was done by widespread post-exposure treatment (PET), not by dog control. When considering pre- or post-exposure treatment for travelers, providers need to remember the stray dog problem in Thailand remains to be resolved. Some of these dogs are rabid.

Some hospitals are clean and modern, with all the advanced technology we have in the West plus the amenities of a 5-star hotel. Bumrungrad (BG) and Bangkok Hospital (BH) are prime examples. Samitivej (SVJ) is also very popular with medical tourists, and they have very active obstetric and pediatric departments (of particular interest to expatriates). Bangkok Nursing Hospital (BNH) is also a popular venue favored by some medical school faculty because of its history of outstanding nursing care. BNH also has an active travel medicine clinic visible as you walk in the front door, and several family practice doctors on staff as well as specialists. BG is investor-owned. BH, BNH, and SVJ are all owned as part of a larger holding company. Piiyavate (PV) is also private and spotless with modern facilities, but is not as convenient for travelers.

Bangkok Christian Hospital is near Chulalongkorn, and is owned by the Church of Christ of Thailand. When I was there in January, they were undergoing extensive renovations. Their main clientele are local Thai people, and they have several regular outpatient clinics. St. Louis Hospital (Roman Catholic) has a rich, 100 plus-year history. It is a large, modern facility, with an adjunct 4-year nursing college (BSN degree). Both institutions are Thai-language, and the director of St. Louis told me that they focus on Thai middle-class patients. Chulalongkorn (Chula) Univer-

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— “Medical Tourism: Implications for Travel Medicine Providers,” cont. from p. 6 —



sity Hospital is the principal teaching hospital for Chula Medical School. They have all modern technology, and their emergency room sees about 3000 patients daily! Professor Henry Wilde (who has lectured at ISTM meetings and is a world-renowned expert on rabies) is my main contact there, and hosted me during my visit.

Patients to these hospitals come from many countries, including the USA (driven by exorbitant costs or no insurance), the U.K. and Canada (due to rationing or delay for elective procedures), plus Europe and the Middle East. I was quite impressed with the large number of patients and families of middle-Eastern origin and from other Islamic countries I saw there. The principal tourism venues, such as Bumrungrad and Bangkok Hospitals, the largest of these, cater to their needs and provide special dining areas and accommodations, including prayer rooms. These are large, private/investor-owned hospitals, not teaching hospitals. These large hospitals offer ‘all-inclusive’ package deals: air fare, hospitalization and procedures, with the entire cost amounting to much less than it would be in the U.S.

Donna Robinson, a private practitioner in Bangkok and member of ISTM who appears frequently on our listserv, was also most helpful to me in arranging visits to these various institutions, as was Dr. Kanwar Singh, who is on staff at Bangkok Hospital and who also provides consultative services to International SOS. Doctor Ramanpal Singh Thakral also has a travel clinic at Bangkok Hospital. Both Doctors Robinson and Ramanpal are listed in the ISTM member directory and are fluent in Thai and English.

Other medical centers are available in Bangkok, such as Mahidol University (Siriraj and Ramathibodi hospitals), which I was not able to visit due to time constraints.

Conclusions: Bangkok is a thriving hub for medical tourism and it is also a reliable center for travelers needing medical attention. Modern medicines and vaccines are readily available in the above-mentioned facilities, including rabies and J-E vaccines. However, Thailand is also a hub for stem cell therapy, which must be viewed with caution. Cardiac stem cell therapy is promising, but needs confirmation in clinical trials (over 300 are listed on www.clinicaltrials.gov).

* The Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) sets standards for healthcare organizations and issues accreditation to organizations that meet those standards in the United States. JCAHO conducts periodic on-site surveys to verify that “an accredited organization substantially

complies with Joint Commission standards and continuously makes efforts to improve the care and services it provides”.

This article is intended to give health care professionals an overview of the medical tourism picture in Bangkok. It is not an endorsement of any one hospital or clinic.

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Letter to the Editor:

The January/February issue of NewShare contained the results of our anonymous survey: Should the ISTM and Travel Medicine Practitioners Become More Involved in Ecotourism? One interesting response was inadvertently left out of the article. Below are the questions we asked and the answers given.

What is your definition of ecotourism? Tourism with respect for the environment. The ultimate ecotourism is avoiding all unnecessary travel.

Much so-called ecotourism is just paying lip service to the concept - traveling vast distances by jet then staying in tribal longhouses and watching quaint dances, etc.

Is ecotourism part of travel medicine? Currently, not much, but it should be. Hopefully, the message will get through that unnecessary travel harms the planet and contributes towards ruining it for future generations. In an ideal world, my job as travel medicine practitioner will be redundant, as people will not travel abroad, but this will never happen in my lifetime.

Should the ISTM and its members take a more active position in promoting ecotourism? This is difficult, as one runs the risks of being accused of preaching, being patronising, and losing business. The motivation has to come from the travelling public.

Do we need more education in the newer concepts of ecotourism? No, I know about it already.

Do you discuss these concepts with your travelers? No, for the above reasons. I discuss it with friends and colleagues. They think I'm crazy.

Are you a responsible traveler? I am a hypocrite - I have travelled twice by plane in the past year. I don't feel good about that. I defend it on the grounds of preserving my marriage!

Name withheld

— "Cholera," cont. from p. 5 —

era outbreaks in western Europe were in the 1860s. If a country can provide safe water supplies and sewage systems to everyone, then outbreaks will disappear. Around 90% of diarrheal diseases can be attributed to contaminated water and/or food, as well as to inadequate sanitation and hygiene. However, in Zimbabwe, little can be done in terms of improving access to safe water and appropriate sanitation in the short term. The focus there must be on the immediate need to treat sick people.

Many of the severe outbreaks of cholera that occurred recently have been caused by consumption of water from contaminated sources. In Zimbabwe it is mainly due to damaged urban water-piping systems and inadequate sanitation, mainly excreta disposal, which results in bacteria being fed back into the water sources. Basic hygiene education, which may be as simple as teaching people the importance of hand-washing, is also needed. It is estimated that such practices can reduce diarrhea cases by around 45%.

More than one billion people in the world do not have access to safe drinking water, while 2.5 billion lack adequate sanitation. Given that the global situation is unlikely to change in the near future, WHO and its partners are left relying for the most part on surveillance, forecasting and responding to cholera outbreaks and monitoring hot spots, mainly in large parts of Africa, Bangladesh, China, India, Indonesia, Pakistan and the Philippines. But predicting the location and timing of a re-appearance of cholera is not so easy. Every year or two we have a large cholera epidemic somewhere in the world. But only official notifications are known. In India, for example, only lab-confirmed cases are reported.

The global cholera picture is likely to remain a challenge. Population shifts from rural to urban areas in low-income countries exacerbate the growth of shantytowns and slums where cholera thrives. With changing climate scenarios and ever-increasing conflict situations around the globe, outbreaks are possible anywhere and at any time. Sound surveillance, preparedness and a capacity for rapid containment should remain the key tools for every country.

Staff from Médecins Sans Frontières treat cholera patients at Budiriro cholera treatment centre in Harare.

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