Training in Travel Medicine and General Practitioners: A Long-Haul Journey!

Karin Leder, FRACP, PhD,∗† Olivier Bouchaud, MD, PhD,‡ and Lin H. Chen, MD§||

∗Victorian Infectious Diseases Service, Royal Melbourne Hospital at the Doherty Institute for Infection and Immunity, Parkville, Australia; †Department of Epidemiology and Preventive Medicine, Monash University, Melbourne, Australia; ‡Hôpital Avicenne – Service des Maladies Infectieuses et Tropicales-Université Paris 13-Sorbonne Paris Cité, Bobigny, France; §Division of Infectious Diseases, Mount Auburn Hospital, Cambridge, MA, USA; ||Harvard Medical School, Boston, MA, USA

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This Editorial refers to the articles by Heywood et al., pp. 368–374, by Morgan et al., pp. 375–382.

Two papers from colleagues in this issue of the Journal of Travel of Medicine explore areas for improvement in the provision of travel medicine advice. Morgan and colleagues report on a cross-sectional analysis of more than 108,000 general practitioner (GP) trainee consultations in Australia,1 while Heywood and colleagues analyzed a postal survey of GPs in Sydney, Australia, with respect to their knowledge, attitudes, and practices regarding travelers visiting friends and relatives (VFR).2

The study by Morgan and colleagues sheds light on how travel is managed in the GP setting by describing the rate and nature of patient visits related to travel medicine. “Travel-related consultations” included both pre- and post-travel encounters, but the majority was the former, involving immunization, medication, advice/education, or health checks prior to overseas travel. Such consultations occurred at a rate of 1.1 per 100 consultations, accounting for 0.68% of all problems managed (sole problem in the consultation in 32%). They were more often managed by younger, inexperienced trainees, and also often involved new patients to the trainee (57%), thereby suggesting lack of appreciation of the importance of a comprehensive overview of the patient’s health status and lack of continuity of care for when providing pre-travel advice.

Travel consultations were also significantly longer than other patient visits, but by a mean of only 2 minutes. Additionally, while trainees more frequently sought in-consultation information for travel-related problems (35%) than when seeing other patients (14%), in nearly two-thirds of cases no external resource was accessed. These findings suggest that both the time required for and the potential complexities of providing adequate travel advice are often under-appreciated.

In sum, the paper suggests that due to insufficient teaching of travel medicine in medical, nursing, and relevant allied undergraduate health courses, those providing advice often lack the required competence. It reinforces the importance of a dedicated curriculum plus continuing professional development in travel medicine to ensure both systematic training in and adequate exposure to management of travel-related problems.

The paper by Heywood and colleagues also highlighted the importance of travel medicine training among primary care providers in Australia. The authors aimed to identify barriers to provision of pre-travel advice at both patient and provider levels, focusing specifically on the perception of risk for VFR travelers. A random sample of 1,975 Sydney GPs working in areas with high migrant populations, 77% of whom were multi-lingual, were sent a 28-item postal survey. Notable findings were a 29% response rate and training in travel medicine reported by only 53% (mostly during medical school). Migrant patients comprised more than half of the travel consultations performed, and VFR travel was frequently reported (47%). GPs consulting in languages other than English (LOTE) were more likely to ask about planned future trips to country of origin compared with English-speaking GPs, but misconceptions regarding VFR travel were common: fewer than 10% of respondents correctly classified various VFR categories, and only 39% considered VFRs to have a higher risk than vacationers.

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Reported barriers to providing pre-travel care to VFRs were late presentation, low perception of risk by VFR travelers, and costs of vaccines and medications, which are issues that have also been identified in other studies. LOTE GPs were also more likely to report lack of culturally appropriate resources and patients’ fear of side effects which are reasonable areas for targeting of provider training.

Heywood and colleagues propose an “opportunistic” approach to identifying future planned travel and providing pre-travel health advice to VFRs in the primary practice setting. With respect to immunizations, this approach is resonant with the cumulative risk consideration of travel immunizations, where the potential of future exposure or life-long exposure influences the decision for immunization. Heywood and colleagues also conclude that multi-lingual GPs in particular require targeted education regarding health risks among VFR travelers. Moreover, efficient use of interpreters with appropriate awareness may enable effective counseling even if the resulting additional cost for such an approach remains to be considered and solved.

While the specifics of GP training and patient encounters may vary across countries, as stated by Morgan and colleagues, “many countries have similar models of primary care and of vocational training to Australia,” thereby suggesting international relevance and generalizability. These two reports of poor training in travel medicine are in themselves not a novel finding, but they serve as a reminder of what needs to be rectified given that travel medicine represents only a marginal part of the activity of the majority of GPs, as reported in Morgan’s study. The fundamental question is: how can this cycle of poor training be broken?

In fact this question is more complex than it might seem, since optimum travel medicine training, especially in the field of pre-travel advice, should address two different issues. The first is basic “technical” knowledge about risk assessment, main indications for immunizations or malaria chemoprophylaxis, and so on. The second is how to properly communicate relevant advice to travelers in such a way that it will be first remembered and then applied. The majority of practitioners are not knowledgeable about pedagogy in health education (this is of course not specific to travel medicine!). Limited data have found mixed results regarding impact of pre-travel advice, although to date pre-travel consultations often are perceived to have only little impact because travelers are “flooded” with various pieces of advice, and choosing two or three priority elements with regard to the specific traveler or travel type might have greater efficiency. Pre-travel advice providers also need to consider that because of their “fear of the needle” certain travelers cannot assimilate any information while immunizations are being performed. This particularly important aspect of travel medicine is often disregarded in training and should be developed.

There is not enough space here to consider all the possible avenues for improvement in travel medicine training and consequently quality of pre-travel advice which GPs, other doctors, nurses, and others specializing in travel medicine can implement. Defining the requirements for minimum levels of knowledge is a first step. Convincing providers of travel advice that the channel used to deliver information is as important as the information itself constitutes a second step which suggests that training in pedagogy in health education specifically tailored to travel medicine is required. Integrating travel medicine training in both initial and continuing medical education is a third step. Providing simple, relevant, and regularly updated national and international recommendations constitutes a fourth possibility.

A number of studies have demonstrated that regular continuing medical education (CME), travel medicine certification, practice-based protocols, yellow fever accreditation for GPs, and registry of travel medicine providers along with education, lead to higher quality advice. For those with a specific interest in travel medicine, a range of courses are now available globally, comprising online or face-to-face teaching, extending from a few hours to many months, and ranging from introductory study days through to diploma and masters level courses (see Table 1). The International Society of Travel Medicine Certification examination is arguably now the most common way to verify whether those involved with pre-travel care have a basic, adequate knowledge in travel medicine. While in some countries (eg, the UK, France, and some US states), some training in travel medicine including yellow fever prescribing is required in order to receive certification as a yellow fever provider (often viewed as a proxy for travel medicine knowledge), in many other countries, health professionals need no such training nor proof of passing an exam in order to provide pre-travel care. Notably, Heywood and colleagues reported that GPs whose practices were accredited yellow fever providers were more likely to report some prior travel medicine training. Therefore restricting licensure of yellow fever vaccines, while not ensuring knowledge of other travel health issues, nevertheless is a logical potential avenue for ensuring some minimal travel medicine knowledge.

Health professionals without training in travel medicine may believe that contemplating a “check-box” of vaccines and/or medications suffices, disregarding an informed risk–benefit discussion. Those with more experience in the field recognize how difficult it can be to optimize individual risk assessment and prioritize advice, plus that subgroups including VFR travelers are particularly difficult to engage. Optimizing the opportunistic delivery of pre-travel advice is particularly relevant and necessary for VFR travelers given their lower propensity to specifically seek advice, but more broadly calls for improved training for all travel health providers, starting at the trainee level.
Table 1 Examples of available travel medicine courses in various geographic locations

Australia

- Monash University, Melbourne (offers an annual 2-day update in Travel Medicine)
- Joint initiative (commenced in 2015) by the Nossal Institute for Global Health and the Burnet Institute, Melbourne together with the Faculty of Tropical Medicine at Mahidol University, Thailand to offer a DTM&H course
- James Cook University, Queensland (offers a Graduate Certificate of Travel Medicine, 6 month full time or part-time equivalent)

France

- Postgraduate Diploma (100 hours) in Travel Medicine: available in six French universities
- 3-Day intensive seminar in travel medicine, Paris

New Zealand

- Postgraduate Certificate in Travel Medicine and Postgraduate Diploma in Travel Medicine, Otago University
- WORLDWISE NZ Travel Medicine Conference (3-day course)

North America

- ISTM Travel Medicine Review and Update courses (2-day course) + the ISTM Certificate in Travel Health™
- Alberta Association of Travel Health Professionals—Annual Travel Health Symposium (2-days)
- Module on Travel Medicine, University of Minnesota Global Health Curriculum. See http://www.globalhealth.umn.edu/education/online-global-health-course/
- Multiple courses including on-line updates (eg, CDC: see http://wwwnc.cdc.gov/travel/page/ce-courses-training)

Thailand

- The Bangkok School of Tropical Medicine, Mahidol University: offers courses from diploma to doctoral levels, including short training courses, DTMH, and the only Residency Training in Travel Medicine

UK

- Travel medicine course run by the London School of Tropical Medicine and Hygiene (5 day course)
- Introduction to Travel Medicine short course run by the Liverpool School of Tropical Medicine (3 days)
- Travel-Health Related Education and Care (TREC)—2 day travel health courses
- Diploma in Travel Medicine, Royal College of Physicians and Surgeons of Glasgow (1-year course)
- Short course in travel health, Leeds Metropolitan University (combines online distance learning, a study day, and competency development in practice)

Declarations of Interests

The authors state they have no conflicts of interest to declare.

References


This is a painted wall in Macau, where five of the rules of basic hygiene are illustrated, each of them being ticked with a red cross in a circle. This applies to children but travelers are concerned as well. Setting: Macau SAR, China. Photo Credit: Eric Caumes.