QUO VADIS? UNDE VENIS?

The Health Hazards of Modern Travel

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This article, by the Assistant Professor of Pathology at the Royal Army Medical College at Millbank, is full of practical advice on how to look after your health and that of your family when overseas. Time was when most of us spent so large a proportion of our service abroad that all but the most ineane were well indoctrinated. But those days are past and there will be many who will read Colonel Vella's words with profit. In consequence, these pages are recommended reading for all those about to serve overseas or to go abroad on holiday. Editor.

Introduction

As soldiers, we are always liable to make sudden journey's abroad. As citizens, like our fellows, more and more of us take our holidays outside the United Kingdom (U.K.) Whether on duty or on holiday, we are all subject to the health hazards inherent in travel and living overseas. At this time of year the 'silly season' is almost on us and it seemed to me that on the basis of "a stitch in time . . ." a few words of advice, borne of some years of Service life, might be helpful. In broad terms, the scourges that afflict the unwary fall into three main groups:—

a. Digestive disorders. b. Bloodsucking insects. c. Contact diseases. So I have dealt with them in that order, finishing with a few tips on medical treatment abroad.

Digestive disorders

Traveller's diarrhoea

I have no doubt that I share a common experience with the majority of my readers that on going abroad most of us suffer a disturbance of the function of our bowels within the first fortnight (Fig. 1).

Much has been written and said about this bane of travel but its causation, and therefore its prevention, is not fully understood as yet.

The British Tommy, with his world-wide commitments in the heyday of the Empire and the Commonwealth, was certainly no stranger to this affliction and characteristically called it by the name of his overseas duty station such as Aden Gut, Basra Belly, Hong Kong Dog, Gypsy Tummy and so on. In recent years other equally emotive epithets have been coined such as Montezuma's Revenge and the Aztec Two-step, or more simply La Turista; and the very latest in descriptive medical appellations are terms such as Drop-out's Diarrhoea and the Overlander's Syndrome, referring of course to the suffering of the disciples of the hippy movement who make the golden journey to Kathmandu.

Prevention. Common sense and personal hygiene will go a long way towards ameliorating this annoying complication of going abroad. I do not think one can prevent it. As far as drugs are concerned, the British Medical Journal says that sulphonamides

Fig. 1.

(sulpha drugs) and the anti-biotic neomycin sometimes may be effective but the widely advertised Entero-Vioform seems of little benefit.

Holiday typhoid and cholera

Although typhoid fever is not an exotic disease foreign to this country, many of the patients suffering from enteric fever that one sees in the United Kingdom are either returning from the various popular "Costas", immigrants newly arrived in the country or others returning after a visit to their native land. Those of us who go South for our holidays in search of the sun should note that the chance of acquiring typhoid increases as we do so (Fig. 2). Cholera, on the other hand, is rightly regarded by our civilian

Fig. 2. Notified cases of typhoid and paratyphoid fever per 10,000 population in the European region in 1972, reported to W.H.O. Figures for Portugal 1969, for Morocco 1970 and for Bulgaria and Romania 1971.

colleagues as an exotic disease. The last epidemic of cholera in Britain occurred in Cleethorpes in 1879. It was transmitted by infected shell fish. This infection was gradually forgotten by the civilian practitioners until in the 1970's the seventh pandemic of the so-called El Tor Cholera came a-knocking over again at the gates of Europe, becoming, for the first time in our generation, a danger to the reader and his family on their package tour to the sunny Mediterranean. Last year cholera claimed 2000 patients, with 45 deaths including one unfortunate British visitor to Portugal. The year before, it had struck in Southern Italy.

Fortunately for our community as a whole, this country is blessed with good environmental sanitation services, coupled with an excellent public health laboratory service which acts as a watchdog. Thus it is highly unlikely that these two intestinal diseases would be able to get a foothold and spread to epidemic proportions in this country. However, so great is the increase in the tourist trade that many of the newly discovered popular resorts must have been swamped by the rush of visitors. As a result, their water supply, sewage and solid refuse disposal may have proved inadequate by the hygienic standards to which we have been accustomed. The sea itself may look fresh, clean and inviting, but even the multitudinous sea may not be all that it seems. The World Health Organization is trying hard to protect the human population against health hazards encountered at the sea side by studying the effects on human health of pollution of beaches and sea water.

Prevention. A few elementary hygiene rules would prove of great if not absolute help to the traveller.

Prophylactic anti-microbial drugs are of questional value, and indeed may be harmful.

Vaccines against typhoid and against cholera are available. The reader is recommended to have these vaccinations done in good time before departure. It is to be noted that they are not 100 per cent protective.

During the journey and for the duration of the period spent abroad, the first line of defence is the wise choice of food and beverages. The safest foods are those which are freshly cooked and are served hot; salads, raw vegetables and unpeeled fruit should be avoided; bottled and canned mineral waters and beverages are generally safe, tap water had better be boiled or chemically treated, and ice in soft drinks may be unsafe.

If possible, avoid living and eating in establishments which appear to have sub-standard hygiene conditions.

Jaundice (infective hepatitis)

It is a well recognised phenomenon that with increasingly better standards of health and environmental hygiene, the population of well-to-do nations tend to lose that immunity to many infections, such as poliomyelitis (in days gone by known as infantile paralysis precisely for this very reason), which had been possessed by previous generations who grew up in an earlier and more hostile microbiological environment than that which is enjoyed today. The price we have to pay as a result of better socio-economic conditions is the loss of this protective immunity and so a liability to be invaded by microbial organisms such as the viruses of infective hepatitis, especially when travelling outside North Western Europe and North America. The result is a nauseating, unpleasant, sometimes serious and occasionally fatal, attack of jaundice.

Prevention. The virologists in their laboratories will manage, in due course, to culture the viruses causing infective hepatitis. This will lead, in the usual course of events, to the preparation of a prophylactic vaccine (such as was done so effectively in the case of Yellow Fever, which killed so many members of the armed forces in the bad old days). Meanwhile, the traveller can have instant, but rather short-term, protection by an injection of gamma-globulin.

Dysentery

There are quite a number of parasites which make the human intestinal tract their home; these are too many to be mentioned here so two examples will suffice, namely the one-celled parasites known as *Entamoeba histolytica* and *Giardia lamblia*.

As regards the amoeba, one cannot classify this parasite as one which is picked up only on the other side of the channel because, in actual fact, it is circulating in this country all the time, lying dormant and causing no distress to its human host. Somehow, in warmer climates, it seems to be more active and to cause not only ulcerations in the intestines but, in some cases to find its way to other organs of the body, such as the liver and the lungs and even the brain. Nevertheless, even in this green and pleasant land, in an age of increasing travel and population movement, the hazards of this disease are likely to increase.

Prevention. Personal hygiene and a wise selection of food.

The second parasite, a simple protozoon with thin filaments called *flagella* which enable it to be highly mobile, is attracting increasing medical attention. It is thought that it not only causes diarrhoea but it may damage the intestinal wall and so hinder the absorption of nutriment, causing the condition known as Tropical Sprue. A senior pathologist working at the London Hospital for Tropical Diseases thinks that this parasite may well be the commonest parasite in Britain, and other temperate countries. In Leningrad it has figured prominently as a cause of diarrhoea in tourists and is thought to be spread by the drinking of water.

Bloodsucking insects

The Mosquito

If you, or a member of your family, should feel unwell after having been abroad, whether on duty or for pleasure, be sure to ask your medical officer (M.O.) or general practitioner (G.P.) to refer you to the nearest service hospital, or to the tropical diseases unit of the civilian establishment, if you happen to live in London, Liverpool or Birmingham. It is the staff of these special centres and that of the armed forces medical services who are conditioned to think habitually in terms of geographic medicine. Every year about five people die in this country because the local G.P. at Much-Binding-in-the-Marsh has not been trained in his medical school to think in terms of malaria, especially of the type known as malignant tertian malaria, which can be present in the patient in so many different guises and aspects and is the deadliest killer of them all. Despite much effort, money and labour and fond hopes of eradication of malaria, this infection still persists in many areas of the world (Fig. 3).

Prevention. You must avoid being bitten by mosquitoes which carry the malarial parasites (Figs. 4 and 5) in their salivary glands and biting parts by:

Fig. 6. The sandfly.

feeds a parasite much bigger than the virus of sandfly fever, namely the *Leishman-donovan* bodies. (Leishman and Donovan were medical officers in the Royal Army Medical Corps and in the Indian Medical Service respectively). In my native country (Malta) this parasite causes anaemia and a big spleen in young children; children brought back to U.K. from abroad suffering from this disease (called *Visceral leishmaniasis*) are likely to be diagnosed as victims of leukaemia unless the doctor enquires carefully about the patient's travels. In some countries, the same parasite may cause unsightly skin lesions, known variously as Tropical sore, Delhi boil, Bouton de Baghdad, and Aleppo boil (Fig. 7).

Fig. 7. World areas of leishmaniasis.

Fig. 3. Malarious areas of the world.

Fig. 4. Anopheles mosquito. The vector of the malaria parasite.

Fig. 5. Malignant malaria parasite in red blood cells.

Sleeping under a mosquito net or in a mosquito proof screened bedroom.

Covering your limbs after dark by wearing long trousers and shirt sleeves rolled down.

Applying insect repellents to face, neck and hands.

Taking appropriate anti-malaria drugs such as paludrine.

I cannot emphasize strongly enough that, on arrival in a new area, you should seek informed medical advice. In some highly malarious areas it may be advisable to use an alternative drug. The parasite may have become resistant to the drug paludrine.

The Sandfly

This sandy-coloured, hairy little insect (Fig. 6) abounds in the happy holiday grounds of many U.K. citizens; namely, the countries bordering the blue Mediterranean. If you get bitten on your holiday in the sun, in the height of the summer season, it may well be ruined by a short sharp illness lasting 3-5 days giving you fever, intense headache and pain behind your eyeballs. This is sandfly fever; fortunately one recovers quickly and completely from it but this small insect vector can also inoculate when it bites and

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Fig. 7. World areas of leishmaniasis.

Prevention. No drug prophylaxis is available at present for these infections; moreover the sandfly's small size enables it to squeeze through the ordinary mesh mosquito net (a finer mesh would be very uncomfortable in warm, humid countries). Insect repellents can be used and are usually effective for about four hours. For the unsightly oriental sores, a vaccine has been prepared and is inoculated in some chosen and inconspicuous site of the body—hundreds of people have been successfully protected in the Middle East and Central Asia. The reader should note that the sandfly specialises in low level attacks. If a choice is offered, the holidaymaker should ask for rooms as high above the ground floor as possible.

The Tse-Tse Fly

This biting fly (Figs. 8 and 9), much bigger than the mosquito or the sandfly, is

Fig. 8. The Tse-Tse fly vector of the sleeping sickness parasite.

Fig. 9. The trypanosome, cause of sleeping sickness.

nature's torpedo-bomber. If you happen to trek on safari in its territorial domain you may find yourself to be the target of its attack, whereupon the tse-tse fly will inject into your body little torpedo-shaped parasites called trypanosomes. In due course you will suffer from fever, skin rash and enlarged glands. Finally, the parasite will corkscrew its way into your brain. It will befuddle your mental processes and you finally succumb to sleeping sickness.

Prevention. Professor B. C. Maegraith, the Dean of the famous Liverpool Tropical School, recommends that such persons as doctors, nurses and members of voluntary service organisations planning to go to the endemic areas in West, Central and East Africa, and who are likely to be constantly exposed to infection should be given some protection by regular administration of the drug pentamidine or suramin. This however is not usually necessary for short term visitors.

The contact diseases

Note: The word 'contact' is used here in the loosest possible way simply as a handy label and nothing more.

Smallpox

So called, I have always thought, to differentiate it from great-pox-syphilis. In London last year a smallpox episode was sparked off by a female laboratory scientist

working at the London School of Hygiene and Tropical Medicine. This led to a public enquiry. An official report was presented to Parliament as a result of which, one gathers, between four to five million people were hurriedly vaccinated; with probably one death resulting from the vaccination. In financial terms the cost of this outbreak is to be reckoned in millions of pounds. This was a home-bred, laboratory outbreak but during 1961-1970, twenty-eight cases of smallpox imported into Western Europe gave rise to 363 further secondary cases, of which 45 per cent were acquired in hospitals or by medical personnel!

It is true that since 1967 the World Health Organisation (W.H.O.) has mounted a universal smallpox eradication campaign. Indeed it is now believed that the disease is eradicated but, until there are absolutely no more cases of smallpox infection, it would be wise not to let our guard down. It is highly advisable that all servicemen and women and civilian medical, para-medical and ancillary medical staffs should be vaccinated at regular intervals.

Prevention. The reader has to realise that official National and Inter-National authorities are more concerned with the welfare of masses and communities than with the personal health of an individual. Hence although it does not matter very much to the authorities if a passenger who leaves U.K. for Bangladesh is protected, one coming back from that country is a different matter altogether. The returning traveller may find himself in quarantine at his first stop unless he can produce a valid International Certificate of Vaccination against smallpox.

Dr. J. Stuart Horner, Director, Health Services, Hillingdon (London) describes the ritual at London (Heathrow) International Airport as follows:

"On arrival on an incoming flight from a smallpox infected area, the passenger is asked to produce the International Certificate. If this is in order he is issued with a yellow card advising him to seek medical aid if he feels unwell. The treatment is provided free under the National Health Service facilities. (This card also alerts the G.P. to the possibility of an unusual imported disease. Unfortunately, many cards are subsequently collected from the floor of the customs hall, where they have been discarded by passengers). If a passenger cannot produce a valid certificate, he or she may be placed in strict quarantine, under the Public Health (Aircraft) Regulations 1970 Act." The moral of this story is, that if you want to travel without hindrance or frustration, make sure you possess a valid International Certificate of Vaccination. But, more important than this, I would strongly advise the intelligent reader to ascertain from his doctor that the vaccination has been successful. If not, the reader should insist on a revaccination, otherwise he or she may well find himself or herself enjoying peace of mind and confidence in his/her immunity which may in fact be quite unwarranted. The mere possession of a legally valid certificate is no guarantee against infection if the holder is unsuccessfully vaccinated.

Tuberculosis and leprosy

These two diseases are considered together in this paragraph because, under the microscope, they present an indistinguishable appearance, namely that of a red rod-shaped bacillus. The first is not a stranger in our midst, since although its incidence has been very much reduced even as late as 1972, there were still thousands of cases of

tuberculosis in this country. Meanwhile, the W.H.O. warns us that tuberculosis is widespread in developing countries. The danger, as I see it, is that forms of the disease and different strains of the tubercle bacillus which are unfamiliar to us in U.K. may be brought in by immigrants or by our own folk infected abroad.

Prevention. While care is taken to screen immigrants as far as facilities allow at points of entry, our own population has been afforded protection against this disease by the availability of a vaccine prepared by two French scientists Calmette and Guérin and known as B.C.G. This vaccine is given to all children before they leave school if they require it.

Leprosy, on the other hand, is a truly exotic disease as far as this country is concerned. For the information in this section I am indebted to Dr. Stanley G. Brown, the consultant adviser in Leprosy to the Department of Health and Social Security.

There are fifteen million cases of leprosy scattered throughout the world, with over five million in Europe. Over nine hundred cases have been notified in England since 1951. In the overcrowded sleeping conditions prevalent in some cities, it is not unlikely that, sooner or later, cases of indigenously contracted leprosy will occur which may be unnoticed for some time. What are the chances that a native of Britain who spends a short time abroad may contract leprosy? They are remote but not negligible. Notwithstanding the generally low risk, expatriates travelling abroad on holiday or on business should not forget the fact that a chance contact at a propitious time, in auspicious circumstances, may result in the transfer of the leprosy bacilli to the skin of a susceptible subject. To illustrate this point; two United States servicemen are reported to have contracted this disease while serving in Vietnam.

Prevention. Personal hygiene. The reader will be interested to know that the same B.C.G. vaccine mentioned under tuberculosis is being used to prevent leprosy in some countries.

Bloody urine (bilharziasis, schistosomiasis)

Fig. 10. World areas of bilharziasis.

In order to increase food production in the developing countries, water is needed to be brought to suitable arable areas. Huge dams are being built which provide not only the water for the thirsty earth but also function as a source of electric power.

Unfortunately, as a side effect of the increased number of watering channels, the snails which carry the fluke (parasite) of the disease known as bilharziasis (Fig. 11)

Fig. 11. The parasite (male and female) of bilharziasis.

also increase and multiply *pari passu* so that the disease goes on increasing and spreading.

The Dean of the Liverpool Tropical Medicine School thinks that this disease is one of the commonest imported conditions in the United States of America (U.S.A.), in Europe and also in this country; and that these infections are not easily missed but may be mistaken for stones in the bladder or even carcinoma. The patient may have been yachting on Lake Victoria, swimming in the rivers of N.E. Brazil or the Sweet Water Canal in Egypt, or wading in fresh water swamps in Nigeria or Lake Chad!

Prevention. The wearing of protective clothing in snail infested waters which will prevent the parasite from reaching the skin and the provision of a safe, parasite free, water are obvious answers. But they may not be always practicable.

Plague

To the majority of the British readers the word plague evokes atavistic images of the Black Death (1348 A.D.), the Great Plague of London (1665-1668) and the Middle Ages (Fig. 12).

The following (Table I) extracted from an American Journal of Public Health showing the presence of plague in the U.S.A. may well come as a surprise.

Table I
Plague in the United States of America

Year	1965	1966	1967	1968	1969	1970	1971
Cases	6	5	3	3	5	13	12

and the W.H.O. states that (in the course of its many W.H.O. assisted missions) in various countries, many patients are affected but are not recorded and notified as plague.

Fig. 12. Plague areas of the world.

Prevention. The American Public Health Service recommends vaccination for persons travelling or living in areas where plague exists. The traveller should try to avoid rodents and their fleas which carry the plague bacillus. The experience of the American Army in Vietnam during the period 1966-1971, with few cases of plague, despite fighting in plague areas, is attributed to the many preventive measures they commonly employed such as combat boots, protective clothing, repellents to reduce risk of fleabites and vaccination.

Bongo-Congo drums. Lassa fever and rabies

I must end this section by first reporting an unusual incident relevant to travel and imported disease. A young 22 year old U.S. Navy journalist-photographer joined her ship at Panama en route for Haiti on 8th November 1973. In Port-au-Prince she bought seven wooden drums. All had goat-hide drumheads with a frieze of hair. Her ship returned to a Florida Naval Station in December 1973 where she gift-wrapped and mailed three drums to her parents in Louisiana and two to friends in Michigan. On the 28th December she noticed an irritation in her left eye which she wrongly attributed to her contact lenses. By 30th December her eye was completely closed and laboratory tests done on her eye secretions revealed the bacillus causing *Anthrax*.

As The Lancet macabrely observed last year, "When your next door neighbour, or your friends or your patients return from a Caribbean cruise with an enviable tan, admire it but beware of their well intentioned gifts or local handicrafts. Jet travel and charter flights have brought some of us near the sound of bongo drums, and we too should be alert that its message may spell out Anthrax".

And secondly, London and the U.K. were alerted and prepared for invasion early in January 1975 by a microbe—the Lassa fever virus. This produced a rather bizarre situation, straight from the science fiction pages of H.G. Wells. Doctor Paul Kennedy returned from Nigeria on the 9th January 1975 on a routine Sabena flight from Kaduna to Heathrow via Brussels; he was suffering from a fever of unknown origin. He was admitted to a London hospital and died within 48 hours. Laboratory investigations

undertaken at the Centre for Disease Control in U.S.A. (at that time the U.K. did not have this capability) proved that his death was due to an infection by a newly discovered virus—the Lassa fever virus, so called from a village of Lassa in Northern Nigeria where the first human victim of this disease was attacked. The virus is spread through the excreta of the multimammate rat, a rodent inhabiting vast regions of West Africa south of the Sahara. Dr. Kennedy's body was placed in a plastic bag, sealed in a coffin, and cremated; one cannot take any chance with this dreaded virus. There are no drugs to treat this infection, there is no vaccine available for protection from it and the only chance of survival is the injection of blood from a donor who has had the infection and, luckily survived.

Finally a reminder to the reader that this country is one of the very few countries in the world today which is free from rabies. If an outbreak of rabies were to occur in the United Kingdom or if rabies were to become established in wild life here, the cost in terms of danger and fear, personal restrictions and destruction of wild life would be considerable, quite apart from the consequential public and private expenditure involved. Not surprisingly, the Government is taking elaborate precautions to prevent cases of rabies in this country. It is hoped that neither the reader nor his neighbour would be foolish enough to play with fire and try to smuggle in their pets, no matter how kindly they feel towards our dumb friends. If you wish to bring an animal into this country you must obtain a licence to do so from the Ministry of Agriculture, Fisheries and Food. The animal can be brought in only through a port or airport authorised to handle animals. It will then be vaccinated against rabies and quarantined for 6 months. Moreover, as from February 1975, the penalties for doing so include imprisonment up to one year and, for the first time ever, an unlimited fine.

As regards the personal safety of the reader, if he or members of his family get bitten or scratched by an animal while abroad, they are advised to consult a local doctor immediately. If the animal is a domestic one, the name and address of the person in charge of the animal and any available information about the health and rabies vaccination status of the animal in question should be carefully noted. One's own name and U.K. address must also be given so that results of any investigations, including laboratory tests, can be passed on. There is no known cure for rabies in humans.

Medical treatment abroad

We are inclined to take our National Health Service (N.H.S.) for granted. I often wonder if we realise how lucky we are to have it, despite the outcries of the popular press. But, the National Health Service covers you only in the U.K. If you fall ill or have an accident on a visit abroad, you will have to pay the full cost of any medical treatment except in countries with which U.K. has a reciprocal health agreement.

Europe. Details of the facilities and procedures to be followed in Common Market (E.E.C.) countries are given in the leaflet SA28 entitled 'Medical Treatment for holiday makers and other temporary visitors to countries of the European Economic Community'. This leaflet is available at local offices of the Department of Health and Social Security (D.H.S.S.) and gives full details, including the way in which refunds may be claimed.

It is most important that you should have form EIII in your possession when in the E.E.C. This is the certificate which proves the entitlement to medical treatment

Fig. 13.

for you and your dependants. Before you leave, but not more than six months before your departure, you should complete form CM.1 (European Economic Community—Application for a certificate of entitlement to Medical Treatment (Form EIII) during a temporary stay in a community country). Form CM.1 is obtainable from any local office of the D.H.S.S. or any employment Exchange Office. You should complete the form and send it by post to the nearest D.H.S.S. office.

The D.H.S.S. advise me that for the countries detailed below, the medical arrangements are as stated:—

Gibraltar. If you normally live in the U.K. and can present your passport, stamped with a temporary residence permit by the Gibraltar immigration authority or your passport and embarkation card from a cruise ship, you are entitled to free general medical treatment at the General Practice Health Centre. For treatment at St. Bernard's Hospital, you will have to pay a small proportion of the total cost. Charges are payable for prescribed medicines.

Austria. On presentation of your U.K. passport, you are entitled to urgent hospital in-patient free. For dependants, 10 per cent of the cost will have to be paid. You will have to pay for other medical services.

Yugoslavia. You are entitled to free hospital and general medical treatment if you need it. A small charge is made for any medicine prescribed.

Bulgaria. If you normally live in the U.K. and can present your National Health Service Card, you are entitled to free hospital or general medical treatment. You will have to pay a charge for medicine prescribed.

Rumania. You get free hospital and other medical treatment but you must pay a charge for medicine from pharmacies. You will have to produce evidence that you normally live in the U.K.

Poland. If you normally live in the U.K. and can present your National Health Service Medical Card, you are entitled to free emergency medical treatment. In the case of non-emergency visit from a doctor or a non-emergency ambulance trip, a small charge is made. You will have to pay a charge of about 30 per cent of the cost of any prescribed drug dispensed in a public pharmacy.

Norway. You are entitled to free hospital in-patient treatment and conveyance by ambulance. About 80 per cent of the cost of treatment as an out-patient or by a general practitioner is re-imbursed. For re-imburement, ask for a receipt (*legeregning*) when paying and take this with your passport to the social insurance office (*trygdekasse*) of the district where the treatment was obtained.

Sweden. Provided you normally live in the U.K., you are entitled to free hospital in-patient treatment and some prescribed medicines. Up to 75 per cent of the cost of general practitioner and hospital out-patient treatment may be re-imbursed if, at the time of treatment, you ensure that you get receipted bills on the appropriate forms. These, together with your passport, should then be presented to the local administrative office (*Forsakringskassa*) in the place where the treatment was given.

U.S.S.R. Under a reciprocal health agreement signed in 1975, U.K. Citizens in the U.S.S.R. (about 50,000 visit the U.S.S.R. annually) needing immediate medical treatment will receive it on the same basis as Soviet Citizens—free of charge.

Malta. The latest reciprocal health care agreement with the Government of Malta came into force on 1 April 1975. The agreement provides for the immediate medical treatment of citizens of one country temporarily resident in the other. Thus an English tourist will be treated at St. Luke's Hospital (the main civilian hospital in the island) and will be charged at the same rate as if he were a Maltese citizen.

Other Countries

In many countries the system of medical care differs radically from our own, and it has not been possible to make arrangements for U.K. passport holders to receive free or subsidised medical treatment. This applies to visitors to Australia, Canada, Greece, Portugal, Spain, Switzerland and the U.S.A.

The reader should be aware that in the countries with which the U.K. has agreements, the range of medical services to which he or she may be entitled free, or at reduced cost, is not always as extensive as that provided under the N.H.S. Serious consideration should be given to the need to insure privately.

For all other countries, you are strongly advised to take adequate private insurance, including cover for your journey, medical treatment and hospital accommodation. Medical treatment abroad can be very expensive, and may well take not only your travel money but all your savings at home!

The compleat traveller

Depending on the nature and geography of your travel, the state of your personal health and your immunological status, the following additional measures may be highly desirable and, in certain circumstances, possibly life saving:

An extra pair of spectacles (and/or a prescription for this), and an extra pair of dentures.

A good supply of drugs, if you are undergoing treatment, plus a note from your doctor explaining the nature of your illness and recommended drug treatment. It has been known that an over zealous customs officer, suspecting illicit drug smuggling, has confiscated a patient's supply of legitimate drugs.

It is obviously extremely important to ensure that all relevant vaccinations have been completed (the contents of this article indicate the sort of hazards against which immunisation is required).

List and addresses of local British Embassy and Consular Offices.

A Metal Tag to be worn at all times bearing your name, address, blood group, religious denomination and essential medical information.

BON VOYAGE AND AUF WIEDERSEHEN

County of Lincoln

Major-General D. G. Levis, C.B., O.B.E., M.B., D.P.H., Colonel Commandant R.A.M.C., was appointed a Deputy Lieutenant of the County of Lincoln with effect from 10th November 1976.