

---

**ORIGINAL ARTICLES**

---

## Death and International Travel—The Canadian Experience: 1996 to 2004

Douglas W. MacPherson, MD, MSc(CTM), FRCPC,\*† Brian D. Gushulak, MD,\* and James Sandhu, BSc,‡

\*Migration Health Consultants Inc., Cheltenham, Ontario, Canada; †Faculty of Health Sciences, Department of Pathology and Molecular Medicine, McMaster University, Hamilton, Canada;

‡Consular Services Bureau, Foreign Affairs Canada, Government of Canada, Ottawa, Ontario, Canada

DOI: 10.1111/j.1708-8305.2007.00107.x

---

**Background.** Death during international travel concerns several levels of the travel industry. In addition to the immediate effects for the traveler, their family and friends, the nature of travel-related mortality has important implications for pretravel health advisors and providers of medical care services.

**Methods.** The Consular Affairs Bureau, Foreign Affairs Canada provides information and assistance to Canadian civilians abroad. Beginning in 1995, the Consular Management and Operations System tracked Canadian deaths abroad notifications. The annual data for 1996 to 2004 was extracted for sex, age, and cause of death by location for all reports received.

**Results.** There were 2,410 reported deaths in Canadians abroad; reported sex was 32% female and 68% male, average age of 61.7 and 60.4 years, respectively. Recorded causes of death: natural (1,762), accidental (450), suicide (92), and murder (106). Country of death reflected the pattern of Canadian international travel for recreation, business, and ancestral linkages. Average age of natural death (66 years) distinguished it from all other causes of death: accidental (45), suicide (41), and murder (43).

**Conclusion.** Natural causes and suicide deaths may be anticipated or planned to occur abroad. The risk of death may be mitigated through personal knowledge and medical assessment and prevention strategies. Deaths due to vaccine-preventable diseases, exotic and infectious diseases were rare in this population. Consular services may be able to provide various types of support. Local laws and customs, as well as international regulations in health and quarantine govern other responsibilities such as funeral services and repatriation of the deceased to Canada.

---

Maintaining health during international travel is one of the fundamental goals for those involved in providing travel health services. This goal is shared with the travel industry, national governments, numerous organizations and agencies. Addressing travel-associated illness, injury, and disease risks is a two-phase process: the recognition and appreciation of the identifiable risk events that occur during international travel and the mitigation

of those risks within the limits of effective interventions and traveler acceptance.

In terms of the hundreds of millions of international journeys completed annually, international travel is generally a safe undertaking.<sup>1</sup> However, a number of travelers do experience serious injury, illness, and death.<sup>2</sup> Of the potential serious outcomes during international travel, there are few more significant than dying. Death during international travel is not rare<sup>3-6</sup> but is uncommonly a focus in travel medicine or health assessments. When they occur, fatalities during travel can generate significant media and public concerns that may influence public perceptions of risk and generate questions for travel health providers.<sup>7</sup> Improved understanding

---

**Corresponding Author:** Douglas W. MacPherson, MD, MSc(CTM), FRCPC, Migration Health Consultants Inc., 14130 Creditview Road, Cheltenham, Ontario, Canada L7C 1Y4. E-mail: douglaswmacpherson@migrationhealth.com; douglaswmacpherson@hotmail.com

of the risks associated with death during international travel can assist in the better identification of at-risk travelers and the provision interventions designed to reduce risk. Those interventions include risk identification, travel event planning, and pre-outcome interventions for risk avoidance or reduction. Additional mitigation can be provided by managing risks inherently present during a life-threatening event and even planning for the consequences of dying abroad before that event occurs.

Risk mitigation is not limited to travel health. Death during international travel can have implications across the entire travel sector. Dealing with a death abroad can involve transportation and accommodation services, tour organizers, governments, health care institutions, and emergency response personnel.<sup>8</sup> As the risks of dying are better understood, strategies for reducing risk exposure in all of these sectors can be considered. Such strategies include more targeted predeparture health assessment, promotion and selection of certain destinations for some travelers with preexisting health problems, attention to the duration of travel, and advice regarding activities and accommodation during the journey. While many activities and behaviors planned and undertaken by travelers may include elements of risk, these determinants become increasingly important when the individual traveler may be outside of their normal cultural, linguistic, or institutional environment. For example, awareness of the capacities of both routine and emergency health services<sup>9</sup> during the journey may affect decisions regarding behavior or actual clinical outcome.<sup>10</sup>

Pretravel health consultation and compliance with travel health recommendations are widely recommended. However, the availability, accessibility, and affordability of travel health services vary widely and the uptake of these services by travelers is not consistent.<sup>11</sup> Few studies have examined the effectiveness of pretravel advice and consultation in terms of traveler behavior and risk taking. Balancing the risks and benefits of widely used travel interventions, such as antimalarial drugs and vaccines, is an emerging field of study and knowledge in the field of travel medicine.

The use of pretravel health services in assessing traveler risk for death, and effectiveness of those services in preventing this outcome in international travelers, is unknown due to the paucity of studies examining this outcome. When deaths during travel are studied, however, it is observed that common travel health interventions such as vaccines, antimalarial drugs, and diarrhea management interven-

tions would have played limited roles in terms of preserving life or preventing death in the majority of travelers' deaths abroad.<sup>12-14</sup> Improved understanding of the causes of death during international travel can support more targeted pretravel health advice and support to those at increased risk of death.

This study describes national outcome data associated with death occurring abroad, including destination, reported cause of death, and basic traveler demographics.

## Methods

In 1993, as part of the Secure Integrated Global Network, that provides communications and computerization services to Foreign Affairs Canada, a novel, national data collection system was developed—Consular Management and Operations System (COSMOS). COSMOS was designed to support the delivery of consular services by the department, and to link headquarters in Ottawa with missions in other countries. The core of COSMOS is the case management program (CAMANT) that provides the tools for management of consular cases by facilitating the collection of standardized information. Within CAMANT, the specific case screens are child custody, citizenship, financial assistance, immigration service, prisoners, and death abroad. The death abroad field gathers notifications of Canadian citizens dying abroad but excludes deaths in federal government foreign service and the Canadian military personnel. All reported deaths data fields include sex, date of birth, date of death; host country; and category of death (natural, accidental, suicide, or murder), when this information was available. This article describes the Canadian death abroad outcomes for 1996 to 2004, inclusive, and provides a 9-year perspective on causes of mortality abroad in Canadian travelers.

### *Data Management*

All extracted notification information was handled in compliance with government and clinical standards to protect individual privacy and health information in accordance with Canadian legislation.<sup>15,16</sup> For the reasons of privacy and personal and health information protection, more specific data on cause or circumstances of death was not available for use in this analysis.

### *Limitations in Data Interpretation*

There are several levels of challenge in comparative analysis of this data set and death outcomes in

nontraveling Canadians. There are reasons to believe that the demographics of travelers and their determinants of health may differ significantly from persons who do not travel abroad either through choice, physical or mental barriers, or restrictions on travel authorizations. Even within the group of international travelers, there will be expected differences in the health determinants and outcomes between short-term tourists, exchange students, business travelers, and “visiting friends and relatives” travelers. Occupational risks associated with international travel, such as humanitarian or emergency relief work or involvement in certain industrial employment opportunities abroad may entail significantly different occupational health and safety standards than a comparable employee may experience in a Canadian work environment. Additional exploration of the significance of these issues for international travelers is presented below.

## Results

From 1996 to 2004, there were 2,410 notifications to the Consular Service Bureau of Canadians dying while abroad. Males accounted for more than twice as many deaths as females (males:females:unknown sex = 681:320:1,409) with average ages of 60.4 (range 0–97), 61.7 (range 0–101), and 61.2 (range 0–100) years, respectively. Of reported causes of death, 1,762 were natural, 450 were accidental, 106 were murder, and 92 were due to suicide. The average age of people dying of natural causes was 66.1 years; accident was 45.2 years, murder was 43.4 years, and suicide was 40.9 years. Table 1 shows the distribution of death by age range group.

The annual reports of death abroad have been increasing for several years as is shown in Table 2. Natural deaths and accidental deaths represent the greatest increases in both proportion and absolute numbers, although in the latter half of this analytic

period, suicide deaths have also increased. Murder, as a cause of death in Canadian travelers, remained a low, but significant, travel-related risk over the study period.

Death by region and selected country data are presented in Table 3. Deaths in Europe (911), the Americas (761), and Asia (643) far exceeded all deaths reported from the African continent (95), a destination often considered to entail a greater degree of health risk. The United States (297), Germany (240), and China (115) were the top three destination countries notifying deaths of Canadians abroad during the study period.

## Discussion

One of the limitations of studies of this nature is the difficulty in comparing the outcomes with nontraveling cohorts. Such data would assist in the better definition of the actual impact of travel on preexisting health conditions.<sup>18,19</sup> The identification of specific factors or situations associated with death during travel may allow for interventions to reduce risk.

Canadian’s international travel destinations can be described as frequencies or durations of stay (see Table 4).<sup>17</sup> Several factors such as the nature of travel and cost contribute to the destination choice and duration of stay. When these factors overlap, such as the elderly traveling great distances for extended periods of time, the potential for any adverse health event including death from natural events or other causes will increase. Interpreting travel destination as a risk for death is challenging as the traveler, the process of traveling, and host country factors are also interdependently related to these outcomes (Table 5).

Behavioral risks occurring in either the traveler or the local population may be associated with travel and contribute to death, particularly accidental or

**Table 1** Death by cause and age range for 1996 to 2004

Age range (y)	Natural	Accidental	Suicide	Murder	Total cases*
0–9	25	13	0	1	39
10–19	8	10	3	5	26
20–29	22	77	14	13	126
30–39	56	56	27	22	161
40–49	141	64	20	13	238
50–59	233	88	14	15	350
60–69	370	41	7	12	430
70–79	441	46	4	6	497
80+	399	9	0	2	410
Total cases*	1,695	404	89	89	2,277

\*Totals do not add up to 2,410 cases due to missing age data in 133 cases.

**Table 2** Cause of death by year of occurrence—1996 to 2004

Year/cause	Natural	Accidental	Suicide	Murder	Total by year
1996	145	47	4	17	213
1997	122	44	7	9	182
1998	163	39	6	4	212
1999	186	47	5	9	247
2000	140	27	8	15	190
2001	163	39	12	13	227
2002	184	34	13	5	236
2003	275	49	17	14	355
2004	383	124	20	20	547
Total	1,762	450	92	106	2,410

intentional causes of death. Extreme tourism, for example, while a niche market in the travel sector, is associated with behavior that can result in injury and death.<sup>20</sup> Operating a vehicle under the influence of drugs or alcohol, participating in unfamiliar sports, particularly in or on water<sup>21</sup> can be associated with serious injury and death. The local capacities for emergency response, rescue, and injury treatments<sup>13</sup> are variables that can contribute to differential mortality and morbidity outcomes when accidents or injuries occur. These factors may be even more significant in some foreign destinations and in the future may contribute to

travelers' decisions in selecting destinations for travel.<sup>8,22,23</sup>

The relationship between international travel and the intent of suicide during travel is unknown. Predisposing or preexisting factors such as mental illness or concurrent illness or disease may be present, influencing these decisions and outcomes. Alternatively, travel may be actively chosen, or events occurring during travel may trigger a decision to end one's own life.<sup>24</sup>

Murder of foreign nationals has been most frequently reported related to the commission of another crime, such as robbery, assault or battery,

**Table 3** Death by region—Canadians abroad 1996 to 2004

Continent	Number of deaths	Subregion	Number of deaths	Selected country	Number of deaths	Rank* Destination
Africa	95			South Africa	15	—
Asia	643	East	150	China	115	11
		South	105	India	67	—
		Southeast	228	Thailand	63	—
				Philippines	84	—
		Middle east	108	Saudi Arabia	53	—
		Oceania	52	Australia	39	—
Americas	761	Caribbean	152	Cuba	22	5
				Dominican Republic	33	6
		Central America and Mexico	232	Costa Rica	31	—
				Mexico	53	3
		South America	80	—		
		Other North America	297	United States	297	1
Europe	911	East	247	Poland	99	—
				Belgium	43	—
		West	664	France	43	4
				Germany	240	7
				Greece	67	—
				Italy	87	8
United Kingdom	44	2				
Total Deaths	2,410					

\*Based on top 15 travel destinations reported in 2004 (from Statistics Canada<sup>17</sup>).

**Table 4** Top 15 countries visited by Canadians (2004)

Rank and country visited	International overnight visits*		
	Total visits (thousands)	Nights spent (thousands)	Average days per visit
1. United States	13,865	107,067	7.8
2. Mexico	705	8,023	11.3
3. United Kingdom	754	9,718	12.9
4. France	590	7,592	12.9
5. Cuba	570	5,204	9.1
6. Dominican Republic	527	4,729	9
7. Germany	328	3,199	9.8
8. Italy	255	2,790	10.9
9. Netherlands	188	1,363	7.3
10. Spain	166	1,843	11.1
11. China	162	3,266	20.2
12. Japan	161	2,076	12.9
13. Hong Kong	149	2,604	17.5
14. Ireland	144	1,633	11.3
15. Switzerland	142	980	6.9

\*Adapted from Statistics Canada.<sup>17</sup>

or sexual violence. Traveler-specific factors are difficult to assign in cases of murder abroad as they are often not known or attempts to avoid “victimizing the victim” are made. Acts of terrorism targeting foreign nationals resulting in death appear to be increasing in both high-risk destinations such as conflict zones and traditionally low-risk areas frequented by tourists. Since 2001, international events and the risks associated or attributed to global terrorism have also influenced travel patterns<sup>25</sup> and tourist volumes in some locations.<sup>26–28</sup>

Natural causes of death are the most common cause of loss of life reported in Canadian international travelers (73%) with skewed distribution to middle and older age groups. Specific cause of death is not known in this group but previous study showed that cardiovascular and respiratory diseases were the most common reported causes of natural death. Pre-existing disease, occult life-threatening processes, end-of-life travel, and acquired causes of natural death during travel in a foreign setting may all occur.

Travelers with unknown or stable medical or surgical conditions may suffer exacerbations during the

**Table 5** Deaths per 1,000 international visits top 15 destinations (2004)

Country visited	Overnight visits*		
	Visits (thousands)	Recorded deaths in 2004	Deaths per 1,000 visits
United States	13,856	40	2.9
United Kingdom	754	13	17.2
Mexico	705	62	82.2
France	590	7	11.9
Cuba	570	10	17.5
Dominican Republic	527	14	26.6
Germany	328	40	12.2
Italy	255	11	43.1
Netherlands	188	0	—
Spain	166	5	30.1
China	162	39	240.7
Japan	161	5	31.1
Hong Kong	149	0	—
Ireland	144	2	13.9
Switzerland	142	1	7.0

\*Adapted from Statistics Canada.<sup>17</sup>

transit<sup>29–31</sup> or postarrival period. Some conditions may even be caused or worsened by travel. Examples include hypercoagulation states and deep venous thrombosis and pulmonary embolization<sup>32–34</sup> altitude-related exposure in compromised pulmonary or cardiac functions and endocrine disorders on prolonged transit routes.<sup>35</sup> Physical or psychological stress during or postarrival may exacerbate or precipitate ischemic cardiac events<sup>36</sup> such as ischemia and dysrhythmia or the consequences of severe hypertension.

The role of social and cultural factors in relation to death during travel is an increasing area of interest in countries with large migrant populations such as Canada. Some travelers with known preexisting life-threatening conditions may make a decision to travel to access health services at the planned destination.<sup>37</sup> Some residents in Canada may choose to return to their ancestral homes when terminally ill to visit family and friends; or, they make an active decision to pass their last days in environments of their choice or in activities that they had always wanted to do before dying. Political and social changes in Central and Eastern Europe have evolved significantly since the demise of the Soviet Union. These changes have been accompanied by increased travel and tourism to locations that were previously difficult to visit and represent the ethnic origin of large numbers of people who migrated to Canada during the past century. This type of return travel in aging immigrant populations may affect patterns of causation and destination in death abroad statistics. These are factors that require additional study in terms of the recent increase in annual numbers of deaths due to natural causes observed in the study.

Natural deaths generally are most often observed as part of the birthing, early development, or advanced aging process. In this study, there were reported deaths in newborns (11 cases), infants and children (14 cases), and young adults younger than 26 years of age (15 cases). The contribution of travel to these deaths is not known as the specific cause of death was not recorded.

The proportion of deaths due to accident (18.7% of all recorded causes), suicide (3.8%), and murder (4.4%) in Canadian travelers was elevated when compared to domestic causes of death. This may reflect the probability that very ill people with impending natural causes of death are less likely to travel internationally and hence are more likely to die in their home country. If natural causes of death abroad are removed from consideration, the proportional risk of death due to accidents is almost equal for Canadian travelers and nontravelers;

suicide is half the risk in travelers, and murder is 3.2 times as likely for travelers.

## Summary

There are several implications from the results of this study. The first is that more detailed assessment of travel-associated outcomes is needed to better understand the specific burden of death in travelers and what component of dying abroad is amenable to protection prevention strategies. Special populations, including pregnant women, middle-aged to elderly persons, particularly males, and people with preexisting medical, surgical, or mental health challenges, should be specifically studied. Additional data collection including information dealing with the specific cause of death, whether the outcome was anticipated or unexpected, and preexisting health conditions would add to the knowledge base related to dying abroad. Other factors that would improve the analysis and interpretation of the issue are country of birth, country of residency, duration of travel, and purpose of travel (eg, tourism, study, business, visiting family or relatives; or planned death abroad).

This analysis will assist governments and health practitioners in the development of educational and training programs to better prepare those international travelers who may need to focus on death prevention and planning. The information clearly supports the promotion of accident reduction strategies for all travelers. It is globally estimated that road traffic fatalities and injuries alone are currently 1.2 and 50 million, respectively.<sup>38</sup> These figures are predicted to increase by 65% during the next two decades.

Knowledge of available health care delivery services, medical transportation and evacuation, and disaster or accident insurance may be particularly advisable for higher risk international travelers. These issues can be expected to become increasingly important as the populations of Canada, the United States, and Western Europe age<sup>39</sup> and acquire chronic illnesses.<sup>40</sup>

Murder avoidance interventions may not be immediately obvious or self-evident for international travelers or to their advisors. Recognizing risk in foreign environments may be unfamiliar to the traveler.<sup>41</sup> Similarly, suicide prevention is a challenging undertaking with increasing profile as an active intervention for life preservation.<sup>42</sup> Identifying risk factors for suicide associated with travel abroad is a complex issue.<sup>43</sup>

There have been recent concerns regarding the risk of death and injury while traveling as a

consequence of both man-made and natural disaster factors. Since 2001, international security issues have influenced the risk of death and serious injury in certain locations and environments.<sup>44</sup> The extensive loss of life associated with the December 2004 Asian earthquake and tsunami has been associated with discussions regarding travel risk education. Personal security awareness and training may be an appropriate recommendation for all travelers.

Improved analysis and evaluation related to the risks of death and serious injury will assist in the development of interventions to reduce adverse outcomes. Ongoing analysis allows governments, professional societies, and the travel and tourism industry in mitigating risk. Evidence-based risk management coupled with knowledge of the proportional risk of illness, disease, and other adverse health outcomes associated with international travel supports this process.

### Declaration of Interests

The authors state that they have no conflicts of interest.

### References

- Dupont HL, Steffen R. Editors textbook of travel medicine and health. 2nd Ed. Hamilton, ON: BC Decker Inc, 2000.
- Spira AM. Preventive guidance for travel: trauma avoidance and medical evacuation. *Clin Fam Pract* 2005; 7:611–637.
- Hargarten SW, Baker TD, Guptill K. Overseas fatalities of United States citizens travelers: an analysis of deaths related to international travel. *Ann Emerg Med* 1991; 20:622–626.
- Paixao ML, Dewar RD, Cossar JH, et al. What do Scots die of when abroad? *Scott Med J* 1991; 36:114–116.
- Provic P. Deaths of Australian travellers overseas. *Med J Aust* 1995; 163:27–30.
- Snizek JE, Smith SM. Injury mortality among non-US residents in the United States 1979–1984. *Int J Epidemiol* 1991; 19:225–229.
- Mydans S. Thailand tells tourists it's serious about safety. *The International Herald Tribune* 2006 Jan 18. Available at: <http://www.iht.com/articles/2006/01/18/news/thailand.php>. (Accessed 2006 Jan 25)
- Thompson DT, Ashley DV, Dockery-Brown CA, et al. Incidence of health crises in tourists visiting Jamaica, West Indies 1998 to 2000. *J Travel Med* 2003; 10:79–86.
- Banerjee K, Carter AO. Waiting and interaction times for patients in a developing country accident and emergency department. *Emerg Med J* 2006; 23:286–290.
- Petridou E, Gatsoulis N, Dessypris N, et al. Imbalance of demand and supply for regionalized injury services: a case study in Greece. *Int J Qual Health Care* 2000; 12:105–113.
- dos Santos CC, Anwar A, Keystone JS, Kain KC. Survey of use of malaria prevention measures by Canadians visiting India. *CMAJ* 1999; 160:195–200.
- MacPherson DW, Guérillot F, Streiner DL, et al. Death and dying abroad—the Canadian experience. *J Travel Med* 2000; 7:227–233.
- McInnes RJ, Williamson LM, Morrison A. Unintentional injury during foreign travel: a review. *J Travel Med* 2002; 9:297–307.
- Guptill KS, Hargarten SW, Baker TD. American travel deaths in Mexico: causes and prevention strategies. *West J Med* 1991; 154:169–171.
- Department of Justice Canada. Consolidated Statutes and Regulations. Personal Information Protection and Electronic Documents Act. 2001, c.5. Available at: <http://laws.justice.gc.ca/en/p-8.6/91355.html>. (Accessed 2006 Jan 12)
- Department of Justice Canada. Consolidated Statutes and Regulations. Privacy Act. Chapter P-21. Available at: <http://laws.justice.gc.ca/en/p-21/93543.html>. (Accessed 2006 Jan 12)
- Statistics Canada. Top 15 countries visited by Canadians (2004). Available at: <http://www40.statcan.ca/l01/cst01/arts37a.htm>. (Accessed 2006 May 26)
- Statistics Canada. Deaths and death rate, by province and territory. Available at: <http://www40.statcan.ca/l01/cst01/demo07b.htm>. (Accessed 2006 Jan 7)
- Statistics Canada. Selected leading causes of death, by sex. <http://www40.statcan.ca/l01/cst01/health36.htm?sdi=death>. (Accessed 2006 Jan 7)
- Shibayev S. Extreme Tourism Claimed Lives of 50 People in 2003. *Pravda* 2003 Oct 28. Available at: [http://english.pravda.ru/accidents/21/97/385/11168\\_extreme.html](http://english.pravda.ru/accidents/21/97/385/11168_extreme.html). (Accessed 2006 Jan 23)
- Wilks J, Coory M. Overseas visitors admitted to Queensland hospitals for water-related injuries. *Med J Aust* 2000; 173:244–246.
- World Health Organization. Essential trauma care project. Available at: [http://www.who.int/violence\\_injury\\_prevention/services/traumacare/en/](http://www.who.int/violence_injury_prevention/services/traumacare/en/). (Accessed 2006 Jan 7)
- Christenfeld N, Glynn LM, Phillips DP, Shira I. Exposure to New York City as a risk factor for heart attack mortality. *Psychosom Med* 1999; 6:740–743.
- Dyer C. High Court upholds right of woman to travel abroad for suicide. *BMJ* 2004; 329:1364.
- Lopez-Rousseau A. Avoiding the death risk of avoiding a dread risk: the aftermath of March 11 in Spain. *Psychol Sci* 2005; 16:426–428.
- McGuire D. Terror in paradise. *Emerg Med Serv* 2003; 32:55–59.

27. Abul Aziz A. The burden of terrorism in Malaysia. *Prehospital Disaster Med* 2003; 18:115–119.
28. Fischhoff B, de Bruin WB, Perrin W, Downs J. Travel risks in a time of terror: judgments and choices. *Risk Anal* 2004; 24:1301–1309.
29. Cummins RO, Chapman PJC, Chamberlain DA, et al. In-flight deaths during commercial air travel. How big is the problem? *JAMA* 1989; 262:31–32.
30. Cummins RO, Schubach JA. Frequency and types of medical emergencies among commercial air travelers. *JAMA* 1990; 263:233–235.
31. Dahl E. Passenger mortalities aboard cruise ships. *Int Marit Health* 2001; 52:19–23.
32. Nedesan K, Nagaratnam M. Sudden death during long distance air travel in an Hb S/C disease patient. *J Clin Forensic Med* 2001; 8:151–155.
33. Schwarz T, Siegert G, Oettler W, et al. Venous thrombosis after long-haul flights. *Arch Intern Med* 2003; 163:2759–2764.
34. Kelman CW, Kortt MA, Becker NG, et al. Deep vein thrombosis and air travel: record linkage study. *BMJ* 200; 327:1072.
35. Sohail MR, Fischer PR. Health risks to air travelers. *Infect Dis Clin North Am* 2005; 19:67–84.
36. Couch RD. Travel, time zones, and sudden cardiac death. Emporiatic pathology. *Am J Forensic Med Pathol* 1990; 11:106–111.
37. CBC News Online. Medical tourism: need surgery, will travel. 2004 June 18. Available at: <http://www.cbc.ca/news/background/healthcare/medicaltourism.html>. (Accessed 2006 May 26)
38. Peden M, Scurfield R, Sleet D, eds. World report on road traffic injury prevention. Geneva, Switzerland: WHO, 2004. Available at: [http://www.who.int/world-health-day/2004/infomaterials/world\\_report/en/](http://www.who.int/world-health-day/2004/infomaterials/world_report/en/). (Accessed 2006 Jan 25)
39. Bosshar D, Frick K. Future of leisure travel—trend study. An independent study created by the Gottlieb Duttweiler Institute on behalf of Kuoni. Zurich: Gottlieb Duttweiler Institute, 2006.
40. Schindler KJ. Travel counseling for the elderly traveler. *Nurs Forum* 2005; 40:107–115.
41. Green MA. Sudden and suspicious deaths outside the deceased's own country—time for an international protocol. *Forensic Sci Int* 1982; 20:71–75.
42. Centers for Disease Control and Prevention. Preventing suicide. Program activities guide. Available at: [http://www.cdc.gov/ncipc/dvp/Preventing\\_Suicide.pdf](http://www.cdc.gov/ncipc/dvp/Preventing_Suicide.pdf). (Accessed 2006 Jan 12)
43. Spooner MH. Swiss irked by arrival of 'death tourists'. *CMAJ* 2003; 168:600.
44. Bogen KT, Jones ED. Risks of mortality and morbidity from worldwide terrorism: 1968–2004. *Risk Anal* 2006; 26:45–59.