AUDINEWS

The Newsletter of the International Society of Audiology

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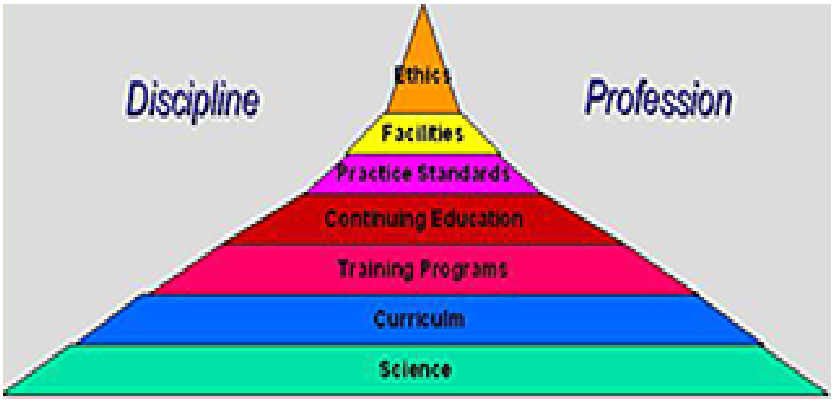
ISA LAUNCHES SPECIAL INITIATIVE

GEORGE MENCHER

A *discipline* is a branch of knowledge or teaching while a *profession* is an occupation or vocation requiring training in the liberal arts or the sciences and advanced study in a specialized topic, subject, or area of academic interest. The International Society has members who work within the discipline of audiology and it has members who specifically work within the profession of audiology. In fact, everyone working in a profession is working in the discipline, but not everyone working in the discipline is working within the profession. Thus, ISA's members who are hearing scientists, ENT/ORL physicians, technicians, educators, etc. are vitally concerned with the discipline, but not as vitally concerned with the profession itself.

As a discipline and a profession evolve, certain key elements must be in place. It is important to start with a strong scientific base. This needs to be followed with an educational curriculum expanding that base and, in the case of audiology, adding a clinical and clinical research component. Next comes continuing education. Without that, ideas become stale, research is not disseminated, and both the discipline and the profession may die. Once a solid scientific and educational foundation is in place, a discipline often moves toward a profession as standards of practice and standards for facilities and equipment evolve. Finally, the entire process is capped by a Code of Ethical Behavior, which relates to all levels of the pyramid from research/science to application of standards of practice.



During our meeting last summer, your Executive Board discussed the efforts ISA has put forth to enhance audiology in all its aspects, both as a discipline and a profession. Your EB has members falling into both categories. We agreed that ISA's role is to support both the discipline and the profession with universal ideas and ideals, models and model programs, practical training and education, funding, and by interacting with other critical groups such as WHO, NGO's and national professional bodies.

The International Society of Audiology has been very active at several of these levels for well over 50 years. Through our journal and world congresses we have helped build a very strong scientific base and been in the forefront of continuing education. What ISA has not done, is be involved in curriculum development, standards of practice and ethics.

continued on page 2....

What's Inside?

ISA LAUNCHES SPECIAL INITIATIVE.....**Continued from Page 1**

In the past curriculum development was not felt to be needed as most of our members came from parts of the world where audiology as both a profession and a discipline were well established. But times change, and so has the need for ISA to respond to those times. In no small part due to our efforts with Hearing International, the World Health Organization, IFOS, EFAS, and a multitude of other groups, audiology is expanding at an exponential rate throughout the world. But, there has not appeared to be any consistency to the training given to those who practice in the area, and there certainly has not been any consistency to the standards of their practice. Further, in some countries, ethical considerations where patient care are concerned have largely been ignored.
As a result of a discussion of these issues, the EB organized a special session at the ISA Congress in Phoenix to present a model curriculum for training audiological personnel, model practice standards for hearing aid fittings which have a universal applicability, and a model Code of Ethics which could serve both as an example for countries developing such a code and could become the actual Code of Ethical Behavior of the International Society of Audiology following a vote of approval by our organization. The three articles, which follow, describe each of these documents. Each document is available either in full or in summary in this issue and in the Member's Only Section of our website (www.isa-audiology.org). We hope you will download the documents, read them in detail and provide us with your feedback. Please participate in this very important task, which ISA is undertaking. You are ISA and we need your ideas! (gtmisa!@yahoo.com)

I: A MODEL TRAINING PROGRAM IN GENERAL AUDIOLOGY

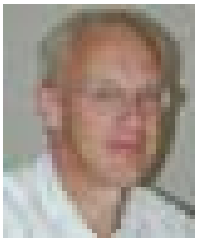
STIG ARLINGER

Various countries in the world show very different pictures regarding the organization of audiological services and the professional groups involved, if any. From a global perspective, audiological services are provided by:

- **Audiologists (with special university training), in independent practice**
- **Audiologists or audiology technicians in a medical environment**
- **Hearing aid acousticians or technicians in independent practice (some formally trained, some untrained)**
- **Untrained staff in a medical environment (e.g. nurses, health technicians)**

Where training programs in audiology exist, they may vary from short informal courses to university programs leading to Bachelor's, Master's or Doctoral degrees.

When the European Federation of Audiology Societies (EFAS) was formed in 1992, one of its aims was to work to improve the quality and standards of European audiology. EFAS has no power to force change, but it can set examples and define goals that will, hopefully in a long-term perspective, lead to improvements in the situation. Thus, in 1999 a group of European professionals in audiology prepared a model curriculum for audiological training in Europe. The model has been discussed for several years and was presented by Bergman and Parving in a generalized form in an earlier version of the Audinews. Over time, the original model has changed, and so has the thinking about limiting its application to Europe. What has evolved after much discussion is a proposal for a draft curriculum for training general audiology personnel which ISA could recommend on a worldwide basis. The proposal being discussed by ISA has a long-term perspective. It is unlikely that many countries will be able to implement every aspect of the general audiology curriculum and program right away, but there is a strong commitment by ISA and by EFAS to having such a program implemented on a long term basis - for the sake of the hearing impaired population.



Stig Arlinger

Continued on Page 3

I: A MODEL TRAINING PROGRAM IN GENERAL AUDIOLOGY...**continued from Page 2**

The draft curriculum was presented at the Phoenix Congress in September. The focus of this training is the general audiologist (GA), the professional seen as the primary person working with and for the hearing impaired. The model program is based on three (3) years of theoretical training followed by one year of practical training, including thesis (research) work covering 3-6 months. It should be noted that in addition to the GA, specialists with different backgrounds at the graduate university level (medicine, engineering, physics, psychology, social work, etc) are expected to complement and support the general audiologist in major audiological centers.
Training of GAs is not intended to replace the services of existing hearing health care providers, but rather, to supplement it. Training programs will be established nationally, according to the special situations and needs of the each country. This process is likely to lead to different realizations of the profession in different countries. Either the GA may be developed as a completely new profession, or the GA curriculum may be adapted to one of the professional groups already active in the field, but should result in a broadening of its scope and an improvement in the quality of patient care.

Approximately one quarter of the three years will be devoted to each of the four main areas of:

1) **Basic sciences**
2) **Medical and diagnostic audiology**
3) **Technical and environmental audiology**
4) **Psychosocial audiology and educational issues, communication repair methods, general skills and specialization**

The proposed curriculum covers the whole broad spectrum of audiology as well as allied fields of importance for the audiologist. It includes diagnostics, re/habilitation, follow-up, educational audiology, occupational issues, financial matters and compensation, counseling of patients, families, other professionals, research, ongoing assessment and evaluation of clinical procedures and services, public education, etc. The three years of theoretical studies are to be complemented by one more practically oriented year with a minimum of 6 months practical work with patients and project work (research) of at least 3 months duration.

The proposed curriculum as presented by Stig Arlinger and Hans Verschuure at the recent ISA Congress in Arizona is to be seen as a model, a starting point to be adapted to national conditions and needs. The curriculum is available on the ISA website (www.isa-audiology.org) for viewing. Please provide comment/ feedback to the author by February 1, 2005 at: stig.arlinger@inr.liu.se

II: GOOD PRACTICE GUIDELINES: ADULT HEARING AID FITTINGS AND SERVICES

STUART GATEHOUSE

At the recent International Congress of Audiology held in Phoenix, Stuart Gatehouse and Bill Noble presented progress and plans on an initiative by the International Society of Audiology concerning Good Practice Guidelines for adult hearing aid fittings and services. The intention is that the ISA produce a generic document that is largely independent of the peculiarities of any particular healthcare delivery context. The document would focus on the process, practises and standards that would guide good practice in any service. The initiative grows out of some national documents in the United Kingdom that have been generalised under the auspices of the International Collegium of Rehabilitative Audiology.

The proposal is to conduct a two-stage consultation process whereby all parties can feed into the process. The first consultation stage ran from the 1st of November 2004 to the 1st of January 2005 and concentrated on the more general purpose and content of the first draft. The first consultation phase was more concerned with what would be present in the document and in what form, rather than the details of its content. Of course, any feedback was and still is welcome. The document includes:

1) **Background & purpose**
2) **Infrastructure & standards**
3) **Assessment & management plan**
4) **Selection, fitting, verification, instruction, counselling and initial fine-tuning**
5) **Follow-up, rehabilitation and support, ALD, fine-tuning**
6) **Ongoing support, surveillance and maintenance**

Following the first consultation phase, a second draft will be produced for detailed comment. The second consultation phase will run from the 1st of February 2005 to the 1st of April 2005, following which a final submission will be presented to the Executive Board of the International Society of Audiology on the 1st of May 2005.

The purpose of this article is to announce the consultation process which will be conducted via a series of websites:

a) **International Society of Audiology website: www.ISA-audiology.org**
b) **Bill Noble's website: www.une.edu.au/psychology/staff/noble.htm**
c) **ICRA website: www.icra.nu**
d) **MRC Institute of Hearing (Scottish Section) websiste: www.ihr.gla.ac.uk**

Each of the websites contains more detail on the process and the mechanism for feedback, which should be e-mailed to Stuart Gatehouse at stuart@ihr.gla.ac.uk

Any queries about this consultation process should be directed to Stuart Gatehouse at stuart@ihr.gla.ac.uk or Bill Noble at wnoble@metz.une.edu.au

PLEASE PAY YOUR DUES!!

If you don't pay your dues we can't give you the IJA (12 issues this year!), the Audinews, the HI Newsletter, and you won't get discounts at conferences worldwide.

Log on (www.isa-audiology.org) Pay Now!

III: A MODEL CODE OF ETHICAL BEHAVIOR

SHIRLEY J. DEVOE

A profession's Code of Ethics forms standards of professional conduct, demonstrates a professions' willingness to monitor itself and to enforce standards of conduct. It also provides guidance and support to the members of the profession, informs consumers and professionals about the kind of cooperation they have a right to expect, and serves as a guide to ethics committees. Our special session at the ISA Congress discussed the value of a Code of Ethics for any organization and shared essential information an organization should consider when developing a Code. Three important markers are necessary for an organization if it is to have credibility with respect to standards of conduct. First, it must have a Statement of Purpose. Second, it must have a Code of Conduct (or Code of Ethics), and third, it must have statutes which outline a consequence of violation of the Code. Of course, there must also be a mechanism for enforcement.

The special session at the ISA Congress was presented by Ieda Russo, George Tavartkiladze and Shirley DeVoe. Comment at the session noted that ISA has a Statement of Purpose, as well as a consequence for violation of rules and a mechanism for enforcement within its statutes. However, it does not have a Code of Conduct or a Code of Ethics. Further, it was also noted that ISA is in the unique position to offer a Model Code which could be adopted/adapted by nations as they develop their own systems. The model Code of Ethics which follows was circulated at the meeting in Phoenix. Members of the committee working on this document welcome comment and feedback. Please contact sjdevoe@yahoo.com before February 1, 2005 with your comment. The model code is presented below and may also be found on the ISA website (www.isa-audiology.org).

International Society of Audiology – Code of Ethics: Draft Model Document (September 2004)

Preface

The Code of Ethics of the International Society of Audiology is designed to formalize the standards of professional behavior for members of the ISA.

The primary goal of the Code is to promote the highest quality of audiological research and patient care. The Code is framed to outline a set of standards that professionals should observe in their clinical and scientific activities.

The Code embodies traditional and contemporary ethical standards, is written in relatively broad language, and is designed to be a dynamic instrument that can grow and change in response to future developments in the practice and science of audiology. While ethical principles may not change with time, developments in science, technology, and clinical practice may lead to a change in application of those principles.

The Code outlines the standards of professional conduct for ISA members. ISA members may be clinical audiologists, hearing scientists, physicians, otolaryngologists, speech and hearing clinicians, or from a variety of other professions. An ISA Code of Ethics, therefore, must be general in nature to respond to the interdisciplinary nature of its members, and yet still maintain principles that are dynamic and meaningful to the member, the general public and supporting agencies. Principles and standards reflect professional competence, client-clinician/researcher relationships, conflicts of interest, relationships with other professionals and the public, and research.

Violations of these standards may serve as the basis for disciplinary action as provided in the Bylaws of the ISA.

Continued on Page 6

CODE OF ETHICS CONTINUED.....**FROM PAGE 6**

Principles

Professional Competence

Members must practice only within their scope of training, experience and competence. Members should engage in the provision of hearing health care and/or research that represents the prevailing standard of practice.

Members shall participate in a regular program of continuing education.

Member-Client Relationship

The member-client relationship forms the foundation for audiological care. Client refers to patients in all forms of clinical settings and/or subjects in all forms of research. Members who engage in clinical practice and scientific research must hold paramount the welfare of the client.

The member shall treat clients with respect, honesty and conscientiousness. The member shall not abuse or exploit the client psychologically, sexually, physically or financially.

The member shall maintain client privacy and confidentiality.

Conflict of Interest

A member is entitled to reasonable compensation for services to or on behalf of clients. A member must avoid practices and financial arrangements that would solely, because of personal gain, influence decisions in the care of clients.

A member should receive compensation only for services actually rendered, and not receive a fee for making a referral or receive a direct commission for an item or service provided to a client.

Members who make written or oral public statements concerning a product of a company from which they receive compensation, or in which they hold a significant equity position, shall disclose their financial relationship with the company.

Relationships With Other Professionals And the Public

Members shall represent themselves and their credentials to the public in a truthful and honest fashion.

A member shall cooperate and communicate with other health care professionals in order to provide the best care possible to clients.

A member shall refrain from unjustifiable criticism of a colleague's judgment, training, knowledge or skills. A member shall not knowingly ignore professional misconduct or incompetence.

A member shall always hold the principles of the International Society of Audiology in the highest regard.

Research

A member shall inform subjects in a research project and obtain their consent. A member shall not bill a client or the insurer for services already compensated by a research study sponsor.

A member shall publish research results truthfully, completely and without distortion. Results of research shall only be widely distributed after the data has been subjected to appropriate review.

PRESIDENT'S PAGE: WILLIAM NOBLE
President, International Society of Audiology

This is my inaugural communiqué to members of the International Society of Audiology, and I confess to some uncertainty about how to come up with sensible-sounding remarks that will have any kind of relevance for the hugely variable backgrounds and circumstances of the Society's composition. It is actually a bit difficult to identify what the ISA is for. Yes, we have a charter and constitution, we engage in a range of activities, including, very importantly, support for the new International Journal of Audiology, and sponsorship of the biennial International Congress of Audiology. But it is hard (or harder) to say exactly what the Society functions for, compared with any of the national professional societies or national/international research-focused ones.

With respect to professional societies, their function is very clear: It is to act as a clearing house for ideas concerning the welfare and prosperity of the membership, advanced through education and training, continuing professional development, and ongoing connection with relevant neighbouring professions. In the case of audiology, that especially means the maintenance of productive relations with ENT physicians and speech pathologists (in cases where they form separate professional groups). One matter, which shows signs of emergence here and there (and one I have no hesitation in advocating), is the validity and value of interconnection between audiology and various sub-fields of psychology. An area that I believe has potential for considerable growth is clinical audiological psychology. There are so many ways in which the management of hearing disorders turns upon an appreciation of the psychological disposition and interpersonal circumstances of the person seeking audiological services, in addition to an understanding of what's called for in terms of optimising signal audibility.

And perhaps it is at this sort of level of reflection that ISA has a role. There is (practically speaking) no such thing as a clinical audiological psychologist — we may well, of course, be able to identify individuals who fit that order of description. Here is a profession waiting to be developed, and it strikes me as entirely legitimate for an international body to be giving expression to what such a profession would offer, most especially in the realm of adult rehabilitation. Psychologists very often form part of the team dedicated to paediatric management. I'm imagining someone involved with the people who form the great bulk of service-seekers, people in their sixties, seventies, eighties and beyond (an enlarging cohort). This person has training in relevant parts of audiological management, and training in relevant parts of clinical and interpersonal management.

I will not run the risk of boring everyone by keeping on this hobby-horse further on this occasion (I'll come back to it, though). All I do want to emphasize is that the ISA can properly engage in broad-brush thinking about where things are headed and where may lie fruitful developments that await being picked up closer to the coal face, perhaps even given real scrutiny at various national professional levels.

I write this on the eve of departure from my summer sunlit Australian university nest for the climatically challenging atmosphere of Iowa, in the mid-west of the USA. There I'll be based for most of 2005, in the College of Medicine at the University of Iowa, and doubtless will draw upon the interesting and exciting things going on there to furnish elements of the President's message in future issues of the Newsletter.

I hope you will have had a peaceful and restful break over the transition time from the old year to the new.

NEWS FROM OUR AFFILIATED SOCIETIES:

AMERICAN SPEECH-LANGUAGE-HEARING ASSOCIATION

Roberta B. Aungst, VP ASHA (RAungst@AOL.Com)

According to the annual report of the Vice President for Professional Practices in Audiology, a considerable number of things were accomplished in 2004. It is the concern of this office to identify issues, to forecast needs and trends, and to initiate appropriate action to enhance audiology practice. Accordingly, eight documents were reviewed for currency and analysis and presented to Hearing Science Assembly at the November, 2005 meeting. They are On the Definition of Hearing Impairment, Audiometric Symbols, Manual Pure Tone Audiometry, Telephone Hearing Screening, Tympanometry, Aids/HIV, Hearing Loss: Terms and Classification, Prevention of Communication Disorders.

The Council for Accreditation of Occupational Hearing Conservation continues to provide certification of Course Directors and Occupational Hearing Conservationists. It also provides educational programming for professional supervisors, physicians, and audiologists who supervise the audiometry portion of a hearing loss prevention program. Meanwhile, the Joint Committee on Infant Hearing is developing guidelines for the purpose of delineating the knowledge, skills, experience, and instrumentation needed to provide appropriate and comprehensive assessment and intervention services to infants and toddlers one month through two years of age.

There are also several active working groups. These are: Acoustics in Educational Settings, Audiologic Assessment Birth to Five, Auditory Evoked Potentials, Auditory Processing Disorders, and Intraoperative Neurophysiologic Monitoring. All of these working groups are pursuing their own activities. There is also a working group on Multicultural Issues in Audiology. This working group is developing two documents: "A Guide for Infusion of Appropriate Multicultural Practice Information into Audiology Practice Documents" and "Multicultural Issues in Audiology."

The Audiology Practice and Consultation Unit has updated ASHA's web page and is developing new consumer packets. A conference on audiology education will be held January 14-16; see the ASHA web page (www.asha.org) for information.

Please Help US With ISA History!!

We have been gathering information about our Congresses. Of particular interest are program books, abstract books, logos, informational flyers, and the like. To date we have something on nearly all of our XXVII meetings – except five! If you, your colleague, your institutional library, or anyone you know happens to have anything from any of the meetings listed below, we would love to borrow it for a few days to photo it. We promise it will be returned! The meetings missing are:

IInd Congress, Paris France, 1955, Dr. Aubin was President
IIIrd Congress, Montecatini, Italy, 1956, Dr. Pieri was President
IVth Congress, Padova, Italy, 1958, Dr. Arslan was President
Vth Congress, Bonn, Germany, 1960, Dr. Langenbeck was President
VIIth Congress, Copenhagen, 1964, Dr. Ewertsen was President

In Volume 10 of Audiology, van Dishoek provided a history to that date (1965). However, the photos he used were all in black and white and not very clearly reproduced. Two of his illustrations are presented here in the hope that they will trigger some memories or ideas from you. I know I have seen the logo from the Padua meeting used at one of our audiology meetings recently.by a hearing aid manufacturer. Anyone else see it? Please help us with our history! gtm

THE RESEARCH MINUTE.....

MARK KRUMM

Cochlear Dead Regions

In the recent Nov/Dec 2004 edition of ENT News[1], Brian CJ Moore discusses cochlear dead regions and how to diagnose them. In the article, Moore indicates that cochlear dead regions are due to non-functioning inner hair cells that, in turn, cause poor cochlear sensitivity. Unfortunately, pure tone stimuli may excite cellular structures adjacent to the cochlear dead regions leading the examiner to underestimate the magnitude of the hearing loss actually present. Consequently, Moore developed a novel test procedure designed to isolate cochlear dead areas more accurately. This paradigm incorporates the measurement of behavioral pure tone threshold measurements in the presence of noise and forms the basis of the Threshold Equalizing Noise or TEN (HL) test. Cochlear dead regions are identified when the TEN (HL) test produces a pure tone threshold shift of 10 dB or more.

Implications for cochlear dead regions may be quite significant. Moore hypothesizes that amplification of cochlear dead regions often results in undesirable outcomes for hearing aid wearers including distortion of speech sounds or hearing aid feedback. Therefore, in the case of cochlear dead regions, he proposes that amplification should be limited to a significantly narrower frequency range (or bandwidth) than most clinicians normally provide clients with hearing loss. Hence, the goal of TEN (HL) is to alert the clinician to the possibility of cochlear dead regions so that amplification can be adjusted accordingly.

A study corresponding to the Moore article, published by Mackersie, Crocker, and Davis[2], studied subjects with suspected cochlear dead regions identified through the TEN test (an earlier version of the TEN HL test). Various speech tests were administered to the subjects in quiet and in noise. In addition, the benefit of wide band amplification was assessed. These data then were compared to a control group matched for hearing loss but not experiencing cochlear dead regions. Results indicated all subjects in the study benefited from wide-band amplification in quiet. However, when exposed to high levels of noise, subjects with cochlear dead regions (in contrast to the control group) did not benefit from wide band amplification.

The authors concluded that one or two isolated mid-frequency dead regions probably do not cause significant communication problems. Further, Mackersie et al, indicated that high frequency amplification should not be routinely restricted to clients presenting cochlear dead regions at 2000-4000 Hz as they benefit from wide-band amplification in quiet conditions. Nevertheless, narrow amplification bandwidths may be an appropriate programming option for individuals with cochlear dead regions who must communicate in noisy environments

In summary, the articles by Moore and Mackersie et al, are interesting from both a clinical and research perspective. These articles may help clinicians navigate through the comparatively new work concerning cochlear dead regions. Information contained in these articles also may provide practitioners clues toward understanding clients experiencing less than expected benefit from amplification.

References:

1 - Moore, BCJ, (2004). The new TEN (HL) test for diagnosis of dead regions in the cochlea. ENT News, 13 (5), 37-38.

2 - Mackersie CL, Crocker TL, & Davis RA (2004). Limiting high-frequency hearing aid gain in listeners with and without suspected cochlear dead regions. J AmerAcad Aud, 15 (7), 498-507.

Editors Note: This is the first time Mark has submitted his new column, "The Research Minute". Mark, a faculty member at Utah State University in the U.S., is one of the those who responded to my plea for help with the *Audinews*. He hopes this regular column will be of interest as he highlights some the newest research in hearing and audiology. You can reach Mark at *mkrumm@cc.usu.edu*. Your comments, suggestions and ideas are very welcome.

Juan Manuel Tato, Sr.

Juan Manuel Tato, Sr

Dr. Tato, the 4th President of ISA (1960-62), the first from Latin America, and a major player in the 1st Extra-ordinary Congress held in Buenas Aires (1954), died in his sleep at age 102.

Dr. Tato is considered the Father of Phono-Audiology in Latin America, and a noted investigator, educator and clinician throughout the world. "El Maestro" (the teacher) was an otolaryngologist who spent a lifetime directing attention to the needs of hearing impaired children and the effects of hearing loss on communication skills. Working with R.Segre, the two developed intervention protocols for hearing impaired children and studied the acoustical characteristics of Spanish. While helping to establish practical courses in audiometry, he helped develop Spanish PB lists. It has been said that Tato was among the forefront of otological surgeons, that that he was a tenacious researcher with an unlimited sense of curiousity.

Tato authored eight textbooks, taught at the University of Buenas Aires and in Bolivia, Honduras and France. His students cover a 50 year period of time! He was honored by special Symposium sponsored by the Argentinian Ministry of Health on the occasion of his 100th birthday! ISA has lost a major contributing force in its development. We mourn the loss of a part of our history.

Submitted by Robert Fifer

DID YOU KNOW?

The International Society of Audiology began as the Societe d'Audiologie en langue francaise and the International Congresses on Audiology which merged in 1953 during the International Congresss of Ear, Nose and Throat in Amsterdam organized by Prof. van Dishoeck. Our first President was Professor Aubin of France. The first Editor of *Audiology* was H.A.E. van Dishoek. The Society was called "Audi" for short!

Contacts: International Society of Audiology (www.isa-audiology.org)

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