NATIONAL HEALTH SERVICE

CONTROL OF VENERAL DISEASE

Summary: This memorandum encloses a copy of the National Health Service (Veneral Diseases) Regulations, 1968, and a memorandum on Contact Tracing in the Control of Venereal Disease.

1. The Minister has made the National Health Service (Veneral Diseases) Regulations 1968, S.I. 1968 No. 1624, which come into operation on 2nd December, 1968. These Regulations, a copy of which is enclosed, re-enact the National Health Service (Veneral Diseases) Regulations, 1948, which required that information about persons examined or treated for venereal disease in hospital should be treated as confidential, with an amendment which permits disclosure to a doctor or a person employed under the direction of a doctor in connection with and for the purpose of treatment or prevention of the spread of venereal disease. The object of this amendment is to facilitate treatment and contact tracing.

2. Also enclosed is a memorandum on Contact Tracing in the Control of Venereal Disease, which has been endorsed by the Standing Medical Advisory Committee and which is also being sent to local health authorities. The importance of contact tracing has long been realised by venereologists, and hospital authorities will wish to co-operate fully with local health authorities in this activity. Additional copies of the memorandum may be obtained from the Ministry.

3. The attention of Boards is drawn to paras. 22 to 27 of the memorandum dealing with legal aspects; in particular to para. 23 about the need to give written instructions to clinic staff requiring them to preserve confidentiality and para. 27 about the need to give written directions to staff concerned with contact tracing.

4. It is desirable that the record form, of which an example is in the Appendix to the memorandum, should be used as widely as possible to facilitate the exchange of information between clinics about contacts. The use of this sort of form has led to successful tracing in the past. It is intended to act as an aide-memoire so that no identifying characteristics will be omitted in difficult cases but it does not need to be completed in every detail, particularly when the name or nickname and address of the contact is given. The completed form need be sent to the medical officers of health only when his office is used as a clearing house for contact tracing. Supplies of the form can be obtained free of charge from the Department. All envelopes enclosing the completed form should be marked back and front "Medical—in confidence (C.T.)" as recommended in para. 11 of the memorandum.

MINISTRY OF HEALTH,
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LONDON, S.E.1.

To: Regional Hospital Boards,
Hospital Management Committees,
Boards of Governors.

F/V12/3B
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MEMORANDUM ON CONTACT TRACING IN THE CONTROL OF VENEREAL DISEASE

Preamble

1. Venereal diseases remain a serious problem in England and Wales as in the rest of the world. The reported incidence of gonorrhoea in 1966 in these countries was 37,483—a formidable challenge; the number of reported cases of infectious syphilis, i.e. syphilis in the primary, secondary, and early latent stages in that year was 1,819.

2. In 1967, of all young people aged 16–19 inclusive, one in 500 boys and one in 440 girls were known to have contracted gonorrhoea; and one in 15,700 boys and one in 32,300 girls contracted syphilis. Of those aged 20–24 inclusive one in 190 men and one in 450 women were known to have contracted gonorrhoea; and one in 7,900 men and one in 23,200 women syphilis.

3. Important epidemiological factors common to both these diseases are:
   (a) an apparent increase in promiscuity—both heterosexual and homosexual;
   (b) asymptomatic infections, especially in women and passive male homosexuals;
   (c) failure to trace sources of infection and to bring them in for treatment;
   (d) a recent influx of immigrants, who seldom introduce infection but contract it in disproportionate numbers after arrival;
   (e) an increase in infection, especially of syphilis, imported by travellers reflecting worldwide increase in prevalence.

Other factors relating to gonorrhoea are its high infectivity and short incubation period, and the emergence of relatively resistant strains. The less widespread use of penicillin for other purposes in the last few years may have influenced the increase in overt syphilis, which is not as susceptible to other antibiotics now more commonly prescribed.

4. Practical ways of breaking the chain of infection are limited. Methods of increasing the resistance of individuals to infection by immunisation are not available at present, nor has there emerged an acceptable method of using prophylactic drugs. "Epidemiological" treatment as a routine of female contacts in whom the diagnosis has not yet been confirmed is not acceptable to all venereologists and the use of this method is a matter for personal decision by the doctor. Physical barriers to infection or inunction with chemicals before or after intercourse, through misuse or for other reasons, have not proved to be reliable safe-guards, and the latter may mask infection with serious late results. We are left with the problem of improving our procedures for tracing potential sources of infection; and, indeed, of the epidemiological factors mentioned in paragraph 3 above, this is the one which holds out the greatest prospect for effective preventive action.

5. Sources of infection are much more likely to be traced if public awareness of the problem is fully aroused by active health education. The screening of special groups is important, e.g. routine testing of pregnant women to reduce still further the now infrequent pre-natal or neo-natal infections and persuading prostitutes, both male and female, to attend regularly for examination as a means of controlling the major sources of acquired infection. Speedy contact tracing is the method most likely to produce quick results; female contacts brought under treatment, especially if they are promiscuous, contribute a disproportionately high degree of success to the control of infection. It is with contact tracing that this memorandum is primarily concerned.

Aim of Contact Tracing

6. The aim of contact tracing is to ensure that the sexual contacts of persons found to be suffering from venereal disease are identified and persuaded to attend a clinic for examination and for treatment when this is necessary. This is not
only in the interests of the individual; it is the most important single preventive measure that can be taken in attempting to control these diseases. Contacts may include not only the presumptive source of infection of a particular patient, but others with whom he or she may have associated in a promiscuous group. They may also include a spouse who is unaware that infection has occurred.

**Necessary Conditions and Action**

7. Contact tracing calls for a cycle of action as follows. The patient provides information to an "interviewer", who either acts on this information or conveys it to a "contact tracer"; subsequent action by either is to seek out the contact and persuade him or her to obtain medical advice. If this person is infected a further cycle will then begin; the first cycle should be completed by reporting the outcome to the clinic which got the information first.

8. If efficiency is to be ensured, the following conditions must be satisfied. The utmost SPEED in obtaining, communicating and acting upon information must be achieved; but at the same time, confidentiality between the patient and doctor must be honoured. The highest degree of standardisation in obtaining and recording information about the contacts must be maintained; responsibilities at each stage of the cycle must be clearly defined, and those taking part must be sure of the legality of their actions.

**Basic Situations**

9. There are three basic situations.

   (a) **The patient is in the United Kingdom, but the named or described contact is abroad.** This situation can be most easily dealt with if the interviewer is authorised by the patient to convey the description of the contact to the Ministry of Health under confidential cover, either directly from the clinic or through the medical officer of health as is commonly done at present. This information is then transmitted, in confidence, by a medical officer of the Ministry to the Public Health Authority of the country concerned. That authority is invited to pass back the results of enquiry so that the cycle can be completed.

   (b) **The patient is abroad, and the named or described contact is in the United Kingdom.** In these instances, information about the contact is received through various channels by the Ministry, whence it is transmitted by a medical officer to the medical officer of health of the local health authority in whose area the contact is alleged to reside. As a result, in some places a "contact tracer" is deployed directly by the medical officer of health; in others the information is passed to the clinic in charge of the local venereal disease clinic and he arranges for the contact to be sought. Again it is desirable that the findings in these cases are passed back to the Ministry so that the originator overseas may learn the outcome.

   (c) **Both patient and named or described contact are in the United Kingdom.** This is the situation that most commonly arises. The essential steps in the cycle of procedures will now be considered in more detail.

**Interviewing the Patient**

10. At present the patients usually give information regarding their sexual contacts either to the clinician or to another "interviewer", who may be a member of the nursing staff, a medical social worker or other officer employed by the hospital, or an employee of the local health authority working at the clinic. On the first occasion patients are often given one or more contact slips and asked to persuade their sexual contacts to attend an appropriate clinic with the slips. This method, which meets with a reasonable measure of success where the contacts are regular consorts but with very little success where contacts are casual, will continue to be useful; and it must be left to the judgement of the "interviewer" whether it is to be employed in individual cases. Consideration should be given, however, to the use in every possible case of a more active tracing method, in which identifying details concerning the contacts are diligently sought, as well as or in preference to the contact slip.
11. If interviews of this nature are to be successful they must be carried out in a room which ensures absolute privacy. Detailed facts must be systematically obtained by the use of a record form (of which an example is given in the Appendix) if no possible clue to the contact's identity is to be overlooked. The form should be enclosed for transmission in an enveloped marked back and front "Medical—In Confidence (C.T.)" to ensure that it will be opened only by staff directly employed in contact tracing. To enable the patient to communicate the facts required, it may be necessary to employ an interpreter, bound by the same degree of confidentiality, particularly where there are many non-English speaking immigrants or seamen. The patient should be asked to consent to the information being passed on or used by the "interviewer". It is an advantage to interrogate all women patients as well as men; this may lead not only to the identification of male contacts, but to that of other women who are already being sought as potentially infected and who may be known to the patients. It is quite unnecessary for the patient's name to be used for the purpose of contact tracing and it is imperative that the patient's name be kept confidential except, perhaps, in very rare circumstances, in which case his or her written consent to its disclosure should be obtained.

12. Persons engaged as "interviewers" (and "contact tracers", whose work is discussed later) need special qualities whatever their professional background. Both tasks call for tact, patience and, on occasion, courage and resource. While personal qualities are the primary requirement, many local health authorities consider that qualification as a nurse or as a trained social worker, whilst not essential, has proved an asset.

13. To ensure that no opportunity to acquire contact information is missed, it is desirable to have an "interviewer" on duty in the clinic at all sessions, unless the clinician himself undertakes this responsibility. To impress upon the patient the need and urgency of his/her co-operation in contact tracing, subsequent attendances of the patient should be as closely spaced as organisation permits.

**Acting on Information about Contacts**

14. The ultimate responsibility for this form of epidemiological control must rest with the medical officer of health. The exact ways in which the responsibility is delegated and discharged in individual areas will be a matter for local decision. Arrangements to this effect should be made by all local health authorities after consultation and agreement between the medical officer of health and the clinic directors concerned.

15. It may well be that the interviewer is the clinician in charge of the case and it is common practice for him to pass information about contacts directly to his opposite number at the clinic in whose area the contact is said to be living. This is a speedy and satisfactory means of transmitting information. If the contact is in the area of the first clinic, the clinician will probably inform his own "contact tracer" at the first possible opportunity, or tell the medical officer of health if the contact tracers are local health authority employees not based on individual clinics.

16. It may be possible for the "interviewer", who is more usually employed by the local health authority and placed at the clinician's disposal, to undertake contact tracing as well, either because sessions are infrequent or because he or she is alternating with a colleague; there are certain advantages in this arrangement. On the other hand in some busy clinics, "interviewers" remain in the clinic at all times and pass the information out to "contact tracers" who stay, 'in the field'. Whatever the administrative arrangement personal understanding and confidence between clinician and interviewer is essential.

17. If the contact resides in another area, the information should be passed in confidence by a method to be agreed between the medical officers of health and the venereologists. It is important that as few people as possible are included in the chain of communication. When doubt exists as to the local arrangements in the area where the contact is believed to reside, the communication should be
forwarded in the standard envelope to the medical officer of health concerned. Speed of action is essential.

Finding the Contact

18. People carrying out this onerous and sometimes disagreeable task will need the sort of qualities which have already been suggested. They will require every possible support and facility if morale is to be maintained. After careful selection, they must be given reasonable status and in giving careful consideration to the grading of their posts, account should be taken of the fact that unusual hours of work may be necessary. It is essential that transport be provided or that they be given funds to cover the use of taxis to make them fully mobile and to make it possible to bring contacts, once traced, to the clinic without delay. This implies that clinics should be open at times when contacts are most likely to be traced in a particular area—a matter for local liaison between the local health authority and the hospital. Mobility may entail the crossing of local authority boundaries and this may be simplified if joint appointments are made between a number of authorities when the local situation appears to justify it, or by agreement between medical officers of health of adjacent areas. The need to provide funds for incidental expenses when seeking contacts at their homes or waiting for them in public houses or cafés should be considered. These workers will need positive encouragement by the medical officer of health or a member of his medical staff selected for this purpose, particularly when the "contact tracer" is not working from a clinic, where he or she is associated directly with individual clinicians.

19. As a result of local consultations and agreements already referred to, it may be considered useful, particularly in large conurbations, to set up a central office where contact tracers could correlate the descriptions of contacts being sought in the area. Thus one contact might be identified by patients in several separate clinics; and once the contact has been found by one worker, the others can be informed, so saving unnecessary effort.

Closing the Cycle

20. When contacts are traced locally, there is little difficulty in ensuring that the outcome of examination is linked with the records of the original patient. When contacts are traced elsewhere the following information of public health interest or in the interest of individual patients should be transmitted to the originating clinic:

(a) The contact has or has not been found.
(b) The contact has been found and has been examined.
(c) The contact has been examined and is not suffering from any disease.
(d) The contact has been examined and found to be suffering from the same disease as the informant.
(e) The contact has been examined and has been found to be suffering from the same disease as the informant and an additional disease.
(f) The contact has been examined and found to be suffering from a different disease from the informant.

The transmission of this information is best done directly from clinician to clinician; but where the information affects epidemiological control, as is usually the case, it is reasonable for the medical officer of health to be informed also. The example of record form in the Appendix shows tear off slips suitable for this purpose. All diagnoses in written communication should be given in code employing the notation used in the form of the quarterly return.

21. Information concerning the success or failure of contact tracing activities in a particular area must be collated. This again is a matter for local arrangement between medical officer of health and directors of clinics. The former will wish to satisfy himself as to the success or failure of these activities for which he is supplying appropriate workers and is ultimately responsible. On the other hand it may be easier for the directors of clinics to derive the information from their records and to make appropriate returns to the medical officers of health at intervals to be arranged.
Legal Aspects

22. The National Health Service (Venereal Diseases) Regulations 1948—S.I. 1948 No. 2517—laid an obligation on Boards of Governors of teaching hospitals and Regional Hospital Boards to take all necessary steps to secure that any information obtained by officers of the Board with respect to persons examined or treated for venereal disease in a hospital for the administration of which the Board is responsible shall be treated as confidential. These regulations have recently been replaced by the National Health Service (Venereal Diseases) Regulations, 1968—S.I. 1968 No. 1624—which retain the general requirement that such information should be treated as confidential and shall not be disclosed but remove any obstacle to the passing of information to doctors or any hospital or local authority staff in this country or persons abroad who may need it as part of their work in connection with treatment or contact tracing.

23. In order to comply with this obligation it is desirable that Boards should require medical and other staff of venereal disease clinics to keep strictly confidential any information they obtain about the identity of a patient, and not to disclose it except as permitted under the Regulations. This should be done either by including a requirement to this effect in their contract of service or by subsequent written instruction.

24. The Regulations do not apply to local health authorities or their officers, but it is desirable that local authority staff working on contact tracing should observe the same confidentiality. Local health authorities are therefore advised to issue similar instructions to such staff.

25. The Minister is advised that the Regulations do not prevent the transmission of information obtained from the patient about the suspected source of his infection. As mentioned in paragraph 12, it is unnecessary for the patient’s name to be used for the purpose of contact tracing, except in very rare cases in which the patient’s written consent to its disclosure should be obtained.

26. The Minister is advised that the Regulations do not absolve any person from the existing obligation to give evidence in a court of law if required by law to do so, or prevent them from giving information about a patient when asked by that patient preferably in writing.

27. The Minister is advised that the legal position of medical and other staff who are concerned with the process of contact tracing is that they are not liable for slander etc., in the absence of malice or improper motives, for anything done as part of their duty as imposed on them by the instructions of their employing authority—either the hospital authority or the local health authority—in pursuance of that authority’s statutory functions. It is therefore desirable that express instructions should be given in the name of the authority to all such officers, including medical officers, interviewers and contact tracers, directing them to take any necessary action, at their discretion, for the following up of any person who they have reason to believe may be suffering from venereal disease, with a view to persuading such persons voluntarily to undergo medical examination and, if necessary, to receive treatment. Advice to this effect was given to local authorities in respect of medical staff in the Ministry’s circular 5/48. It is desirable that it should now be applied to all staff involved in contact tracing, whether employees of the local health authority or of the hospitals.