On Reports and Rapport in VD Control

The reporting of venereal diseases has been a subject of tremendous interest and controversy in the United States for well over half a century. The bulk of attention has been given to syphilis and gonorrhea because of their relatively high prevalence and serious consequences; until recently it was not recognized that many communicable diseases other than the five classic venereal diseases—syphilis, gonorrhea, chancroid, lymphogranuloma venereum, and granuloma inguinale—are frequently spread through sexual contact.

It has long been known that syphilis and gonorrhea are grossly underreported in the civilian population, hence an unreliable indicator not only of the magnitude of the problem but even of trends in incidence. Most of the early studies of prevalence and trends were directed toward syphilis,[1] although some efforts addressed both diseases.[2,3] An excellent review of the problem, the inadequacies of available information, and suggested rational approaches was presented by Nelson and Crain in their book, *Syphilis, Gonorrhea and the Public Health*.[4] Most of their comments are as germane today as they were in 1938 when the book was published.

Basically, there is no disagreement as to the purpose to be served by complete reporting of syphilis and gonorrhea. Few would argue with the desirable aims set forth by Parran in *Shadow on the Land:*

> First, every early case [of syphilis] must be located, reported, its source ascertained and all contacts followed up to find possible infection. Second, enough money, drugs and doctors must be secured to make treatment possible for all cases. Third, both public health agencies and private physicians throughout the country must be realigned to form a united front, and reeducated to use scientific, modern methods in their joint fight against syphilis.[5]

The same statement is applicable as regards gonorrhea.

Since public health clinics are generally in complete compliance with reporting laws, the major deficiency lies with the private practitioner of medicine, although hospitals—both public and private—are also unreliable reporters of communicable diseases.[6]

What are the obstacles to securing complete reporting with identifying information? The article by Rothenberg, Bross and Vernon[7] in this issue of the Journal discusses several aspects of the problem, and lists the following impediments:

- the view that reporting is unimportant in the control effort and of no benefit to the physician or patient,
- the patient's efforts to prevent reporting,
- the belief that reporting violates the privacy implicit in the doctor-patient relationship,
- the lack of rewards for reporting, and
- cumbersome reporting procedures.

Other authors[8] have listed such factors as

- unawareness of the legal requirement for reporting,
- the belief that others will report, and
- lack of trust in the reliability of health department's maintenance of confidentiality and tactful management of contact investigations.

Since it is obvious that the success of venereal disease control is dependent upon enlisting the support of medical practitioners, hospitals, private clinics, patients and their contacts, and an informed public, it is reasonable to ask whether there is some substance to their perceptions and whether our own requests or legal demands are reasonable and essential to the attainment of our goals in venereal disease control. We must examine the present situation and consider the soundness of our position in terms of what is most likely to yield the information required and still elicit the cooperation of all concerned.

As previously mentioned, determination of the size of the problem, the distribution of cases in the population and incidence trends are among the primary reasons for desiring reporting. We now have reports which include virtually 100 per cent of patients diagnosed in public health facilities but a considerably smaller proportion of those diagnosed in hospitals[6] and by medical practitioners.[7,8] No doubt the size of such samples could be greatly increased by intensive health department efforts to secure complete, or at least improved, hospital and physician reporting. The question is whether the results justify the effort. If our only goals are those stated above, it would appear to be more cost effective and less a cause of contention between public health officials and the groups whose support is sought if well-designed sampling techniques were used. Rothenberg and his colleagues[7] describe their experiences with one such method and refer to another approach successfully used in Rhode Island as reported on by Shaffner, *et al.*[9] These examples of sampling systems, if refined and universally adopted, should allow estimates of adequate accuracy of the incidence, distribution, and trends. Another source of data, in lieu of physician reports, is the reporting of positive tests by laboratories, although this would be more useful for gonorrhea than for syphilis. Methods would have to be devised to ensure that the proportion of physicians utilizing the laboratory services did not fluctuate materially. Many other approaches to estimating incidence and trends have been reported in the literature but cannot be listed here. The point is that reporting by name cannot be justified as essential to the counting of cases or determining their distribution.

Another reason for requiring reporting is to provide the basis for real control measures: interviewing the patient for contacts, followed by location, examination and treatment of infected contacts. These can be linked to education of the patient and possibly the involved physician.

The situation differs somewhat depending upon whether the patient has syphilis or gonorrhea. In the syphilis patient, several services can be rendered. If the patient is presumably infectious (primary, secondary or latent of less than one year's duration), interviewing and contact tracing services can be offered or some assurance received that reasonable efforts in this respect have been made. In all cases, the registry file can be searched to determine if the patient has a record of previous diagnosis and treatment. This information can assist both the physician and patient. The number of

syphilis cases reported by physicians and positive tests reported by laboratories is small enough so that most health departments should be able to provide these services.

Regarding gonorrhea, it is clear that the present venereal disease control apparatus cannot hope to carry out a complete program of interviewing and contact investigation on all cases; therefore, increased efforts have been made to concentrate the energies of health department personnel on selected groups of patients. Recently, major efforts have been directed at the improved management of female patients with pelvic inflammatory disease (PID). The health department, particularly in urban settings, can provide outpatient follow-up or outpatient management of cases and gynecologic consultation. This phase of the program has been enthusiastically received by overloaded hospital outpatient departments and, to a lesser extent, individual practitioners. Equally important is the interviewing of patients and contact investigation,[10] as the patient is obviously at high risk of reinfection and subsequent sterility. Among the contacts of women with PID, the proportion of infected patients located who have asymptomatic gonococcal urethritis may be as high as 50 per cent. The asymptomatic male patient poses a special risk to the public health since he has no obvious reason to seek diagnosis and treatment or to suspect that he may be a source of serious disease to his sexual partner(s).

Another group requiring special attention are those patients infected with penicillinase-producing *N. gonorrhoeae* (PPNG). Although these strains have not become widespread in the United States, they present a frightening potential problem.[11] When recognized, strenuous efforts must be made to carry out rapid and thorough contact investigation. Frequently, through laboratory reports, the health department will learn of the presence of PPNG in a patient as quickly as does the physician. In this situation practically universal cooperation can be secured to get the patient appropriately treated and contact investigation initiated.

From the foregoing, it is apparent that the real justification for reporting venereal disease cases by name is that it will lead to specific actions that will control the disease. This is the reason health officials support legislation requiring case reporting with personal identification. While repeal of these laws is not advocated, efforts to stringently enforce them with penalties to non-reporters seem unreasonable and counter-productive unless the health department does indeed use this information as the basis for providing services. As Rothenberg, *et al,* indicate, there is little evidence that private physicians are, as a group, unwilling to cooperate in worthwhile public health endeavors. By providing useful assistance—such as laboratory diagnostic services, appropriate information regarding the incidence and management of patients, convenient consultation services, and educational material or contact referral slips for his or her patients—a strong groundwork for mutual assistance can be established. A continuing dialog through personal or telephone contact, publications, newsletters, lectures to medical societies, and studies published in professional journals are all useful means of initiating and maintaining fruitful relationships. With this ongoing program, most physicians can be persuaded to cooperate in those instances, such as the control of PPNG cases and their contacts, where definite useful steps will be taken by the health department. The same is true of hospitals and clinics which as a group have cooperated in PID programs when tactfully approached by competent health department representatives.

Let us then encourage and assist our colleagues in performing their roles consistently but reserve our insistence on meticulous observance of the letter of the law for those situations of importance where we are, in fact, providing those services which were implicit in the arguments which led to the enactment of these laws. In this way, we shall be conserving our human and fiscal resources for more productive uses and promoting a sense of partnership among health professionals and institutions rather than fostering an adversary relationship.

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