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Letter to the Editor

Disease Intervention Specialists as a Corps, Not Corpse

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To the Editor:

In his editorial,[1] Golden describes the metamorphosis of partner notification (PN) since the late 1990s, a time by which PN had fallen into disrepute and disuse, into Expedited Partner Therapy (EPT) for the curable sexually transmissible infections (STI). As principal advocate for EPT he and his colleagues are to be thanked for their determined efforts to reinvent PN, once dubbed "the sickly man of public health".[2] Essentially, EPT consists of the STI-diagnosed patient delivering the appropriate prescription to exposed partners. Programmatically, such an approach shifts PN responsibility from health worker to patient. Although EPT must be welcomed as preferable to doing nothing, disease control authorities must not discard some of the more useful contact tracing responsibilities.

EPT is inherently capable of achieving 2 of the 3 purposes served by seeking the contacts of STI patients[3]: the ethical obligation to warn exposed partners and reduction of the community STI burden. EPT is not, however, designed to achieve the third: elucidating local transmission dynamics. This requires on-the-ground investigation to identify the networks hosting transmission in (nearly) real time.[4] Indeed, it is here that we should reiterate the central distinction between PN and contact tracing: the former focuses on the individual's welfare whereas the latter, on the community's.[3] Thus, although I endorse EPT, use of specialized contact tracing efforts in special circumstances (e.g., periodic monitoring of ongoing transmission for selected sexually transmitted bacterial and blood-borne infections[5] and for STD/HIV outbreaks) retains its importance for providing epidemiologic insights.

During the last 25 years, contact tracing has been programmatically deemphasized and PN, inadequately implemented.[6] Importantly, the corps of federally funded, trained, and state-assigned STI "shoe-leather" epidemiologists was, in effect, decommissioned about 40 years after its formation in 1948. The pivotal loss was the specialized set of disease investigation skills, especially "their ability to respond to newly emerging and ongoing threats of STDs".[7] They once exported STI interviewing and contact tracing skills, along with high professional standards (commitment, persistence, and willingness to challenge patient denial and evasiveness) to local health jurisdictions, a consequence of being assigned to virtually every US state and territory.

But that was then and this is now. Given the fluid nature of STI/HIV dynamics and given the breadth of new and newly emerging infections in both rich and poor countries,[8] the need and demand for specialized shoe-leather epidemiologic skills is likely to remain brisk. Although EPT deserves a solid place in the STI control armamentarium, its implementation should not obviate this need. Disease intervention sleuths should be a corps, not corpse.

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