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‘How Old Are You, Boy?’ An Autobiographical History of Working as a Sexual Health Adviser in 1980s Britain

David Evans[*]

Summary. This is an autobiographical history of working as a sexual health adviser in the mid-1980s, a time of significant change in UK sexual health services. There are very few first-hand accounts of health advising in the literature. Autobiography is an increasingly accepted method that uses the historian’s personal experience to understand the past. My work as a health adviser comprised two distinct elements. First, I saw patients with gonorrhoea, syphilis or non-specific urethritis in the clinic, and encouraged them to inform their sexual contacts, sought information on their contacts in case they did not attend, and provided a health education intervention. If the patient defaulted, or if the contacts did not attend, I sought them in the community. The second role involved providing counselling for those undertaking testing for HIV. My account provides unique testimony of lived experience in, and reflections on key issues concerning, 1980s UK sexual health services.

Keywords: health adviser; sexual health; contact tracing; sexually transmitted infection; HIV counselling

Introduction

The year was 1987 or 1988. I had been trying to trace an older African-Caribbean man for several weeks. Several female patients with gonorrhoea had all recently named him as a sexual contact so we were certain he was an active case. He had been at the clinic before, so we knew we had his real name and past address, but we were not sure of his current address or whether he might be living with one of his female contacts. It was always a delicate business going knocking on doors, not knowing whether the contact or one of his partners might open the door. We had strict rules of confidentiality so I could not say to anyone else why I wanted to speak to him. If a woman answered, from experience I had learned to make clear I was not from the police, the welfare fraud squad or any other enforcement agency. I could not even say it was health-related as many in the community would suspect that only the ‘special clinic’ sent male health workers around your home to find you. But I was usually able to defuse any tension by my slightly apologetic, mild-mannered middle-class demeanour. In those pre-mobile phone days, all I could do was ask if they knew where I might find him. Usually the answer was a shrug ‘no.’

[*]Centre for Public Health and Wellbeing, University of the West of England, Bristol BS16 1QY, UK. E-mail: david9.evans@uwe.ac.uk

David Evans is Emeritus Professor in the Centre for Public Health and Wellbeing at the University of the West of England, UK. Previously he was Professor of Health Services Research at UWE and before that he was one of the first non-medical directors of public health in the UK National Health Service in 2001. He has published on the history of UK sexual health services, the development of multidisciplinary public health in the UK and on patient and public involvement in the UK NHS.

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On this occasion I was lucky, and found him in. He answered the door and when I had ascertained he was indeed who I was looking for, I gave him the usual spiel: we had reason to believe he might be infected with gonorrhoea, and I asked him to come into the clinic with me to be tested and, if positive, treated. He reluctantly agreed, but to my surprise he turned to me and asked:

> *'How old are you, boy?'*
> Nonplussed, I replied:
> *'Thirty.'*
> Then he asked:
> *'And how old is gonorrhoea?'*
> I thought for a moment:
> *'I don't know, but several thousand years anyway.'*
>
> *'Boy'* he replied, *'gonorrhoea has been around for thousands of years. And you're thirty. And you're trying to beat gonorrhoea. Give me a break!'*

Shaking his head, he gave me a pitying look. But at least he still consented to come into the clinic for testing and treatment.

I had been a sexual health adviser for a year or so at this point, and this conversation had a significant impact on me. Not only did it bring home to me how very different lay and professional understandings of health could be, but it crystalised questions for me about how effective our traditional contact tracing approach was to containing the spread of sexually transmitted infections (STIs).[1] And on reflection 35 years later, I am astonished at how little I knew or understood at the time about the postwar Black experience of the National Health Service (NHS) in general, or sexual health services in particular.[2] His opening question using the term 'boy' to describe me was rich with meaning. He was subverting the usual power inequality between patients and health-care professionals as well as the long racist history of White people calling adult Black men 'boy'. I had much to learn then about racial inequality and racism in health services, which continues to provide abundant material for critical reflection now.

This is a historical autobiographical account of working as a sexual health adviser in the mid-1980s, a time of significant change in sexual health services in the UK. The history of sexual health advising is only recently emerging from obscurity. I have previously written about how sexual health advising developed from the almoner role and contact tracing in VD clinics[3] in the early twentieth century to seek recognition as a profession in the last quarter of the century.[4] There are very few first-hand accounts of health advising in the

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[1] STI and STD (sexually transmitted disease) are often used interchangeably, though STI is now the preferred term in the field as it is seen as more accurate (as some infections are asymptomatic) and less stigmatising. STIs were referred to as venereal diseases (VDs) until the late 1970s.

[2] Roberta Bivins, *Contagious Communities: Medicine, Migration & the NHS in Post-War Britain* (Oxford: Oxford University Press, 2015); Anne Hanley, 'Migration, Racism and Sexual Health in Postwar Britain', *History Workshop Journal,* 2022, 94, 202–222.

[3] The term 'VD clinic' was replaced by 'special clinic' and then by 'genitourinary medicine clinic (GUM)' over the 1960s and 1970s.

[4] David Evans, ''Initially This Work Was Done by Doctors, Often Ineffectively ...': The History of Sexual Health Advising in Twentieth-century England', *Modern British History*, 2024, 35, 414-434.

literature; a comprehensive search of the literature identified only Melissa Parker's ethnographic description of working as a health adviser in a GUM clinic in the 1990s.[5] But her role was primarily research, working on a study of sexual networks relating to the transmission of gonorrhoea. A central element of her narrative is the conflict she encountered with the clinic's permanent health advisers, which she attributes to their low status and lack of job security within the clinic. She is also more interested in the wider culture and ethos of the clinic and all its staff, with little on the lived experience of working as a health adviser.

Three other accounts of note are Roger Davidson's history of contact tracing in Scotland from the advent of VD clinics c. 1918 through to the arrival of HIV/AIDS in the mid-1980s, Antje Kampf's history of contact tracing in New Zealand from the Second World War through to the mid-1980s, and John Potterat's autobiographical account of contact tracing in Colorado from the 1970s to the 2000s.[6] Davidson drew on archival sources as well as oral evidence from retired venereologists and contact tracers, although no contact tracers are directly quoted in the article. Nor does Davidson use the term 'health adviser' which only came into common use at the end of the period he was examining. As he is primarily interested in public health policy, clinical practice and legal constraints around contact tracing, he has little to say on the professions engaged in contact tracing, their recruitment, training or the experience of doing the role.

Although focused on New Zealand rather than the UK, Kampf's work is significant in that it directly addresses the lived experience of the contact tracer drawing on an in-depth interview with one retired contact tracer as well as the only other known published interview with a New Zealand contact tracer during the Second World War. Issues explored include the lack of training and professional development, the social stigma of working on STIs, the impact on the contact tracer's own social life and the risk of violence. Potterat describes his personal journey from a short-term contact tracing role in Colorado, USA to becoming a long-serving Director of a STD/AIDS programme. These accounts by Parker, Davidson, Kampf and Potterat provide useful comparisons with my own lived experience of contact tracing as a sexual health adviser in mid-1980s Britain.

Autobiographical accounts are rare but not unheard of in contemporary history of medicine.[7] As Jaume Aurell and Rocio Davis have argued:

> Though historians have traditionally mistrusted personal narratives as critical documents, in recent decades experimentation and theorising on forms of life writing from the field of history have grown substantially, as historians discuss how autobiographical narrative may contribute to understanding both the past and the processes of accessing it.[8]

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[5] Melissa Parker, 'Stuck in GUM: An Ethnography of a Clap Clinic', in David Gellner and Eric Hirsch, eds, *Inside Organizations: Anthropologists at Work* (Oxford: Berg, 2001), 137–156. There were several earlier accounts by hospital almoners working in VD clinics in the 1930s and 1940s, some of which discuss the early days of contact tracing for STIs in the UK but do not describe the role in detail. See Evans, 'Initially This Work Was Done by Doctors'.

[6] Antje Kampf, 'A Little World of Your Own: Stigma, Gender and Narratives of Venereal Disease Contact Tracing', *Health,* 2008, 12, 233–250; Roger Davidson, "Searching for Mary, Glasgow': Contact Tracing for Sexually Transmitted Diseases in Twentieth-century Scotland', *Social History of Medicine*, 1996, 9, 195–214; John Potterat, *Seeking the Positives: A Life Spent on the Cutting Edge of Public Health* (North Charleston: Createspace, 2015).

[7] See, for example, Donald Bateman, 'The Good Bleed Guide: A Patient's Story', *Social History of Medicine*, 1994, 7, 115–133.

[8] Jaume Aurell and Rocio Davis, 'History and Autobiography: The Logics of a Convergence', *Life Writing,* 2019, 16, 503–511.

Autobiography, however, is largely based on the individual's memory and this presents a number of issues for historians. Although historians take a variety of positions on how the nature of memory should be conceptualised, there is a high degree of consensus on some key aspects of the use of memory in history. Critically, memory is generally understood as a reconstruction not simply a retrieval of past experiences, shaped by social and cultural factors, and the individual's preconceptions, beliefs and knowledge.[9] Further, memory is not only constructed but also filtered by mechanisms of selection and omission; there will be importance silences, gaps and forgetting in the construction of memory.[10] Memory is often unreliable; we can 'remember' things that never occurred, conflate experiences that took place at different times, or 'remember' as our experiences things that were actually the narrated experiences of others.[11] Memories can and do change over time in response to changing personal circumstances, cultural norms or social and political developments.

In principle, it would be better to draw on multiple and diverse memories by a range of health advisers from the 1980s, so that common themes and areas of contestation can be identified and analysed. Hopefully in time these will come, but in their current absence then a single autobiographical account can be of real value in describing experiences and identifying issues previously unexplored—as long as it is done with sufficient critical reflexivity around the unreliability of memory.[12] This account will inevitably be singular and subjective, and will be subject to biases of selection, omission and distortion as in all autobiographical writing from memory. But as an experienced researcher of both contemporary and historical public health, I am at least conscious of such pitfalls in presenting my own memories. I am also aware that the experiences I am recounting occurred 35 years ago; some of them appear clear in my memory, like the encounter I describe above; other memories of my time in the GUM clinic are hazy at best. Although recognising that these assessments may themselves be unreliable, I have done my best to specify when my memory is less certain in the account that follows.

Beginnings

I was working as a staff nurse on an oncology ward in a hospital in Bristol, UK in early 1987, and looking for a new job due in part to the very hierarchical nature of the nursing profession and the lack of attention to the emotional work of caring for those dying from cancer. A recruitment ad caught my eye for a 'Health Adviser in STDs,' an area I had not worked in previously. It involved both health education advice and contact tracing for 'traditional' STIs such as gonorrhoea and syphilis, but also a new role of providing pre- and post-test counselling for the recently introduced HIV antibody test. HIV/AIDS was still relatively rare, and little understood in the UK at the time, particularly outside

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[9] Geoffrey Cubitt, *History and Memory* (Manchester: Manchester University Press, 2007); Joan Tumblety, ed., *Memory and History: Understanding Memory as Sources and Subject* (Abingdon: Routledge, 2013).

[10] Joan Tumblety, 'Introduction: Working With Memory as Source and Subject', in Joan Tumblety, ed., *Memory and History: Understanding Memory as Sources and Subject*, (Abingdon: Routledge, 2013), 4.

[11] Cubitt, *History and Memory*, 80.

[12] Lindsey Dodd has similarly argued that a single oral history narrative, even when based on substantial misremembering, can be valuable in revealing broader social processes: Lindsey Dodd, 'Small Fish, Big Pond: Using a Single Oral History Narrative to Reveal Broader Social Change', in Joan Tumblety, ed., *Memory and History: Understanding Memory as Sources and Subject* (Abingdon: Routledge, 2013), 34–49.

London. I was a bit more aware of it than some UK health workers, as I was originally from San Francisco, one of the early epicentres of the HIV/AIDS pandemic, though I had left and moved to the UK before it had been recognised.

I do not recall or have a copy of the job description, but I know my nursing qualification was one of several desirable criteria that meant I was eligible to apply for the post. I therefore applied and was shortlisted. The interview took place is an imposing hospital boardroom with what I remember as an intimidatingly large number of GUM consultants and managers on the interview panel. A female candidate got the job, but to console me I was told that there might well be another post coming up in a few months' time and that I would be considered. A few weeks later I received a call on the ward from the GUM manager who informed me they had secured additional funding for a new post, and would I like the job? I was delighted and accepted immediately. After working out my notice for a few weeks I began my new role. There were several significant changes I experienced which are worth noting.

The most visually obvious was that I exchanged my nurse's uniform (white tunic with coloured epaulettes indicating my status as a staff nurse) for a white coat to be worn over a jacket and tie. Thus, I now looked like a doctor rather than a nurse as this was the male doctors' standard dress code as well. As far as I can remember none of us wore name badges in those days, so unsurprisingly patients initially were not able to tell health advisers from doctors. I did not consciously exploit this, but in retrospect I'm sure the authority suggested by the white coat aided me in extracting contact information from patients.

The second change was that I moved from a nursing grade to an administrative grade. The change in level of pay was insignificant, and I did not give it much thought. Though I did not realise it at the time my nursing qualification was later to prove very helpful. Fortunately for me I kept up my nursing registration, more out of a sense of solidarity and camaraderie with my previous colleagues and my past self than any belief that I would ever return to a clinical nursing role.

My quality of life improved enormously. In my previous nursing role, I had had to do a week of night shifts every month, which I found very difficult as I did not adapt well to trying to sleep in the day. The GUM clinic required some flexible working to cover morning, afternoon and early evening clinics, but no night or weekend work.

On starting my health adviser role, I was given some rudimentary training by the senior health adviser, which essentially consisted of observing him for a few sessions and then him similarly observing me. This was done for both the traditional STI work and for the HIV counselling, which I will shortly describe in turn. There was not to my knowledge any training programme for health advisers at that time, although there had been an NHS Training Authority 1 week contact tracing course introduced in 1981 which it had been hoped would become an essential qualification for health advisers, but which seemed to have disappeared by the time I was recruited or at least was not available in our clinic.[13] I cannot recall if we had a copy of the comprehensive handbook of contact tracing the Health Education Council had produced a few years previously, but if we had, it was not a document we consulted regularly.[14]

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[13] Evans, 'Initially This Work Was Done by Doctors', 427–429.

[14] Health Education Council, *Handbook on Contact Tracing in Sexually Transmitted Diseases* (London: Health Education Council, 1980).

With hindsight, I was unprepared for this role. I was White, heterosexual, male and middle-class. My nurse training (UK-based and non-university though I already had a history degree) had included virtually no discussion of sex, sexuality or STIs. There had been no mention of the specific health needs of lesbian, gay, bisexual, trans or queer (LGBTQ+)[15] people, the impact of homophobia, and in particular, nothing about the sexual health of gay and bisexual men who were at the time in the UK the community most affected by the sexual transmission of HIV. Similarly, there was little on cross-cultural issues in health care, the impact of racism on health or the specific health needs of different Black and ethnic minority communities. There had been an emphasis on interpersonal skills, listening skills and empathy, which was useful, but little formal training on counselling. I believed myself to be anti-racist, feminist, a supporter of gay and lesbian equality, and committed to patients' rights and empowerment, whilst working in an institution that I regarded as overly hierarchical and authoritarian.

Working as a Health Adviser in a Genitourinary Medicine Clinic

I was inducted into the STI work first, as the senior health adviser was keen to hand on most of this work as he prepared to commence the HIV counselling clinic. The STI clinic was on one of the lower floors of a large 1960s concrete monolith of a building. Patients entered from an internal corridor by separate male and female doors into single-sex waiting areas with a reception desk behind a secure glass screen. It was called simply 'Clinic 1' with no mention of GUM or STIs, presumably to make it more discrete for patients who might be embarrassed to be seen entering. There were no windows in the waiting rooms, and the seats were arranged in narrow L-shaped patterns. I personally found the waiting rooms quite oppressive and often felt an atmosphere of barely repressed anger or resentment in the male waiting room when it was full of men. If (rarely) a mixed-sex couple wanted to be seen together they had to sit on hard plastic chairs in the corridor outside the clinic, thus communicating to any passers-by who knew the focus of Clinic 1, that they were waiting to be seen in the GUM clinic.

The layout of the clinic followed the classic STI format which had changed little from the 1920s.[16] From the waiting areas there were corridors which opened onto doctors' offices, nurses' treatment rooms, a laboratory (which opened either end onto both the male and female corridors) and finally the health advisers' room and a staff room. My memory is that due to the layout, only the staff room and the health advisers' room had windows, and the whole clinic had a neglected and shabby air. Until the advent of ring-fenced HIV/AIDS funding in the late1980s, GUM clinics had been treated as a Cinderella service in the NHS and the physical state of the clinic reflected the low priority given to funding and developing STI services.[17]

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[15] The acronym LGBTQ+ is used here to denote a range of non-heterosexual individuals and communities due to the continual change in accepted terminology although the term was not commonly used at the time. The terms 'gay' or 'homosexual' were used commonly and interchangeably in the clinic at the time.

[16] Lawrence Harrison, 'The Design of Venereal Disease Treatment Centres', *British Journal of Venereal Diseases,* 1934, 10, 223–232.

[17] Department of Health, *Report of the Working Group to Examine Workloads in Genito Urinary Medicine Clinics* (London: Department of Health, 1988).

Patients who tested positive for non-specific urethritis (NSU, common in men, not tested for in women),[18] gonorrhoea (common in both men and women) or syphilis (rare) were either brought to me by a nurse after diagnosis and/or treatment, or I was asked to call them from the waiting room when finished with the previous patient. If the nurses thought the patient would be resistant to waiting to see the health adviser, they would often 'hold' them in the treatment area until I was free to see the patient, to avoid them 'doing a runner' from the waiting room.

Our job as we understood it was threefold. First, we sought to explain to patients the importance of notifying all their sexual contacts and encouraging them to attend for testing, and treatment if appropriate. To this end, we gave them a 'contact slip,' which had information about the clinic times and location, and an anonymised code number to enable the contacts to be linked with the index patient if they attended. Second, being aware that some patients would take the contact slip but not actually deliver it to their contacts, we sought to obtain as much information as possible about their contacts—names, addresses and/or telephone numbers, genders, ethnicities, approximate ages and other identifying details. Our policy was to encourage the patient to notify their contacts first, but if they did not or were not able to, we would then try to contact them ourselves. Finally, we sought to provide as much health education we could in the short time available, including encouraging safer sex by providing condoms for both vaginal and anal sex.

In my view at the time, patients tended to fall into one of four categories. First, were those for whom getting a STI was no big deal, often gay men, who were happy to notify their contacts themselves, although frequently they honestly said it was a casual sexual encounter and they did not have any contact details.

Second were those who were resistant or hostile, did not want to see a health adviser, would 'do a runner' if they could, but if held by the nurses to meet us, would either deny all knowledge of their sexual contacts' names or whereabouts, or give false details.

Third were those who absolutely denied they had had any casual sexual contacts, often claiming they were in monogamous relationships. In some cases, this may have been true, as it may have been their regular partners who had had a casual sexual encounter. But quite often we knew this was not true, as we had already seen their casual sexual partner who had independently come to the clinic for testing, been found to be positive for an STI and named our patient as their casual sexual partner. In such cases, we could not of course breach the confidentiality of the other patient so had to appear to accept our patient's account, but our focus still had to be on them notifying their regular partner, and any other partners, so that individual or those individuals could be tested and treated if necessary.

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[18] NSU, also called non-gonococcal urethritis (NGU), was a common diagnosis in men who had a urethral discharge and who tested negative for gonorrhoea. It is often caused by chlamydia, but this was only gradually being realised at the time I worked in the GUM clinic and was not routinely tested for at the time due to technical limitations of the laboratory methods then available. Chlamydia is now recognised as the most common STI in both men and women and can have serious complications for women's reproductive health. See Michael Worboys, 'Chlamydia, a Disease without a History', in Simon Szreter, ed., *The Hidden Affliction: Sexually Transmitted Infections and Infertility in History* (Rochester: University of Rochester Press, 2019), 153–183.

Finally, there were those who were distraught both at catching a STI but more so, at having had a casual sexual encounter outside their regular relationship, having caught a STI and therefore having to face telling their regular partner both that they had been unfaithful and that they may have given them a STI. This group was in some ways the most challenging to work with, as they knew they should tell their partner, but also half hoped that if they did not tell, perhaps their partner would have escaped catching the STI and therefore they would not have to expose their unfaithfulness. Unsurprisingly, this group were very reluctant to give us their regular partner's contact details, as if the patient subsequently decided not to tell the partner, they would not want us contacting their partner a few weeks later and doubly exposing them as both unfaithful and having potentially exposed the partner to an untreated STI.

I think that I and all the clinic staff were aware that the passage of the patient through the clinic was rather like an assembly line: reception, doctor for history taking and possible diagnosis, nurse to do tests, back to the doctor for confirmation of diagnosis and prescription of treatment, back to the nurse for treatment and then to health adviser for contact tracing and health education. As health advisers, we rigorously followed the government's strict requirements on confidentiality for STIs,[19] but we were less concerned about patients' right to be involved in their own care decisions and to give informed consent for partner notification. We tried to establish rapport with patients, engage them and gain their confidence and trust. We were polite and expressed sympathy for any dilemmas they had around informing partners, in particular if they had been unfaithful to a supposedly monogamous partner such as a spouse, and now needed to inform them that not only had they been unfaithful but that they were at risk of a STI. After encouraging them to contact their partners, and even if they agreed to do so, the clinic was intent on getting all their partners' contact details in case they failed to contact them or convince them to come in for testing.

I would try to start in a non-directive way, gently asking for example 'would you like us to contact them for you …?' But there was often resistance to sharing contact information, and I would persevere and become increasingly insistent. There were clearly times when I (and other health advises) used the power inherent in the clinic and the white coat to press patients into sharing contact information that they would rather not have done. This usually took the form of emphasising and then re-emphasising to male patients that women were often initially symptomless with STIs but that untreated could cause them serious illnesses like pelvic inflammatory disease. I believed it was for the greater good of the contacts and of the wider public for us to use every means at our disposal to pressure patients to give full details on their contacts. The fact that some patients chose to resist or avoid this questioning, does not mean it was not experienced as oppressive by them.

Between seeing patients, I would spend time either catching up on paperwork (we had to laboriously cross-reference patients and contacts), seek to contact defaulting patients and contacts by phone and letter where possible and appropriate, or contacting other clinics where the contacts lived in locations covered by other UK clinics. There was no computer in the health adviser room at that time, all our records were kept on paper

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[19] *National Health Service (Venereal Diseases) Regulations, 1974.*

cards. It could be quite time consuming to link contacts with previous patients as full and correct contact details were often not available, and sometimes false names and/or addresses had been given. Sometimes we were reduced to looking people up in the telephone book.

As well as my work in the clinic, a significant amount of my time was spent in the community, seeking out male contacts who had not attended and those who had defaulted on returning for treatment and/or for test of cure. My female colleague did the same for female defaulters and contacts. I would set out with a list of such patients and contacts and drive round Bristol knocking on their doors or those of their known sexual contacts. Most frequently, I was driving around the more deprived parts of the city, visiting run-down tower blocks, knocking on windowless doors in long bleak corridors. As described at the beginning of this article, it was often a frustrating and unsuccessful task, with either no response or a suspicious reception from a female occupant, but the 'buzz' of the occasional success in tracking down and getting someone into treatment generally kept my motivation up.

One little discussed but omnipresent area of tension in the clinic was around race and racism. All the consultants were White, as were most of the junior doctors and all three health advisers. There was one Asian senior registrar who was well regarded by clinic colleagues, but struggled to find a consultant appointment elsewhere in the field (as often happened to Black and immigrant doctors at the time[20]) although ultimately he was appointed as a consultant. As far as I can recall, the senior nurses (those who had done the 3-year Registered General Nurse or RGN training and were appointed as charge nurses or staff nurses) were all White. Those who had done the 2-year State Enrolled Nurse (SEN) training were regarded as second-level nurses and had no prospect of promotion, and included the only Black members of nursing staff.[21]

By contrast, the clinic staff estimated that approximately 25 per cent of our male patients were African-Caribbean, a much higher proportion than in the community at large.[22] As my work focused on the male side, I am not sure what the proportion of African-Caribbean women attending the clinic was, but my sense was that it was much lower. I do not remember any explicitly racist comments directly directed towards the African-Caribbean men by clinic staff, though I was rarely in the room for their clinical encounters with doctors and nurses; but my sense was of a generally negative attitude amongst many staff (e.g. beliefs that such men often missed appointments, turned up late and/or were non-compliant with treatment) and a corresponding antagonistic attitude amongst many of the African-Caribbean men to the service they were receiving. Unsurprisingly given this context and more general experiences of racism in the NHS and wider society, many African-Caribbean men (like some other men) choose not to wait to see the health adviser, or if they did, were unwilling to give details of contacts and

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[20] Samara Linton, 'Black and Asian Doctors Still Face Discrimination When Applying for Jobs in the NHS', *British Medical Journal,* 2021, 375, n2451.

[21] The racist bias which pushed well-qualified migrant Black women into SEN rather than RGN training has been well-documented, e.g. by Adina Batnitzky and Linda McDowell, 'Migration, Nursing, Institutional Discrimination and Emotional/Affective Labour: Ethnicity and Labour Stratification in the UK National Health Service', *Social & Cultural Geography,* 12, 181–201.

[22] I am unsure how accurately or completely the clinic collected ethnicity data at the time as this was before systematic ethnic monitoring was introduced in the NHS in the 1990s.

did not want a health education lesson. Interestingly, these tensions I experienced in the clinic were not replicated in the community. When knocking on doors in predominantly Black communities, I never felt the sense of supressed anger or aggression by patients I had observed in the clinic. By comparison, both Davidson and Kampf mention the potential for violence against contact tracers, and there has long been a problem of aggression, abuse and/or violence directed against a wide range of NHS staff.[23]

The one occasion I can remember of a racist remark involved one staff member (a White male nurse) speaking to the assembled nurses and administrative staff in the staff room during a break.[24] One female nurse was the only Black member of staff present. I cannot remember what the remark was, but from my perspective it was clearly racist and should have been challenged, but I did not and neither did anyone else present. At the time I felt great discomfort not challenging the remark, but I believe I did not do so for several reasons. One was clearly cowardice, linked to the knowledge that we were dependent on the goodwill of the nurses to hold and bring patients to us as health advisers, and not wanting to alienate the speaker or any of the other nurses who might share his views or merely object to a health adviser 'telling off' a nurse when we had no authority over them. At the time I also consoled myself that the Black nurse had not challenged the speaker, and if she chose not to, what business did I have to interfere. This was of course a very naive view and illustrates my failure at the time to really understand the realities of racism, the privileged position I held as a White professional in the clinic and the very significant difficulties faced by marginalised Black staff in challenging racist language within a predominantly White workforce.

The Advent of HIV Pre- and Post-Test Counselling

A few months after I started work, the new HIV testing and counselling 'Clinic 15' opened in a different part of the hospital. Although the entrance was nondescript, patients entering through a small car park at the back of the old eighteenth-century part of the complex, once inside it was as welcoming and non-clinical as possible. Newly decorated, with soft lighting, attractive prints on the walls and comfortable seating, it was a complete contrast to the old STI clinic. Seating was also available for couples, including both single-sex and mixed-sex ones. Not only was it much more patient-friendly than the old STI clinic, but it was better furnished than any other outpatient clinic I was aware of in the hospital. This was only made possible by the new ring-fenced HIV/AIDS allocation the hospital trust had received from central government.[25]

From a personal perspective, the other big difference was that this was a health adviser-led clinic. Staffing was limited to a health adviser to carry out the pre- and post-test counselling and a nurse who both acted as the receptionist and took the blood specimens for testing; there were no doctors routinely in the clinic. Pre-test counselling followed a set

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[23] Paul Linsley, *Violence and Aggression in the Workplace: Practical Guide for All Healthcare Staff* (Abingdon: Radcliffe, 2006).

[24] I recognise now that I may well have overheard more racist comments but, due to my privileged White professional position, did not pay these sufficient attention at the time to recall them now.

[25] Virginia Berridge, *AIDS in the UK: The Making of Policy 1981-1994* (Oxford: Oxford University Press, 1996).

protocol agreed in the department, closely following national Department of Health and Social Services (DHSS) guidance.[26] The key aims of the session were to ensure patients gave informed consent for the test, and were prepared for the implications of both a positive and negative test. Although clearly the results of a positive test were much more life changing, in those days even a negative test could have potentially serious implications including affecting relationships, employment, mortgages and insurance. At a time when the antiviral AZT was not yet introduced into routine clinical practice and many people with AIDS were dying before treatment was available, patients needed to understand the potentially life-threatening implications of a positive HIV diagnosis. We also gave some limited technical information, including what was known then about the sensitivity and specificity of the test; crucially, the potential time lag between infection and a positive test result meant that for those recently at risk, a repeat test in 3 months was advised.

At the time I viewed Clinic 15 patients as falling into one of two categories. Those most at risk were men who had sex with men (MWHSWM),[27] in particular those who had had unprotected anal sex. Although the overall prevalence of HIV was relatively low in Bristol at the time, MWHSWM were at higher risk as the two groups significantly affected by HIV in Bristol were MWHSWM and injecting drug users. The latter were much more likely to be tested in drug services than with us.

Much more common as patients were heterosexuals who had had a casual sexual encounter, usually unprotected vaginal intercourse, and were worried that they might have put themselves at risk of HIV. If they were otherwise in a regular monogamous relationship, then they were further worried that they might have put their regular partner at risk of HIV and/or that they would have to tell them about the casual sexual encounter.

It could take nearly a week to get the results back from the lab, so we always made the return visit for results a week later. This was of course a very stressful waiting period for the patients, although in most cases, they also needed to come back for a repeat test in 3 months' time if their risk encounter was recent.

Thankfully, the vast majority of our patients were HIV negative. In these cases, we told them the result immediately, and then gave them some time to take it in before giving them further information and safer sex advice.

Giving a positive HIV result was very distressing and required significant preparation. I have a vivid memory of the first time I gave a positive result. We discussed it as a health adviser team first, and made sure there was a doctor available to see the patient after I had given him his result. Naturally, he was devastated, although I think he was expecting the result. I referred him both to our clinic doctor and to the local voluntary sector support group, the Aled Richards Trust, named after the first man who had died of AIDS in Bristol (later incorporated into the national Terrence Higgins Trust). Although there were some tensions between the clinic and the Aled Richards Trust, overall the relationships at the level of health advisers was good, and it felt vital to be able to refer HIV-positive

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[26] Department of Health and Social Security, *AIDS-Information for Doctors Concerning the Introduction of the HTLVIII Antibody Test* (London: Department of Health and Social Security, 1985).

[27] MWHSWM was an acronym increasingly used at the time to describe gay, bisexual or other men who had sex with men but did not necessarily identify as gay or bisexual. The acronym now is usually given as MSM.

patients to a voluntary sector partner which had strong input from an active local gay community.

During this time, an exciting opportunity emerged for me due to my status as a registered nurse. The DHSS advertised a number of nursing fellowships relating to HIV/AIDS; I applied and was successful in obtaining one to look at HIV testing, counselling and contact tracing (or partner notification as it was increasingly being called) in the USA. At that time, there was no national policy relating to contact tracing/partner notification for HIV, and much debate within the genitourinary medicine field as to its utility and ethics, given that unlike the traditional STIs there was at that time no treatment for HIV/AIDS. For my fellowship I visited STI/HIV services in San Francisco, and in Colorado where the clinic was doing active partner notification for HIV. I duly compiled a report on their differing approaches to HIV partner notification for the DHSS. It was not intended for publication and I do not know if it influenced policy at all, but there remained a vigorous debate in GUM clinics, professional bodies and the medical literature as to whether partner notification should be extended to HIV. A minority of clinics developed policies and practice of more active partner notification.[28] The ethics of partner notification with HIV were of course very different to those for traditional STIs. With the later, treatment and a cure could be offered, potentially avoiding illness and long-term consequences like pelvic inflammatory disease. With HIV, partner notification could potentially identify unknown infected individuals; if this led them to change behaviour, then it could reduce further spread. Nonetheless, there was no treatment on offer to the contacts identified as HIV positive who might then progress to AIDS and death. Within our clinic, HIV-positive patients were encouraged to inform their sexual contacts, but there was no direct staff follow-up. At the time I was personally undecided, seeing the potential benefits but concerned about the ethics of more active partner notification by staff, so was content with our clinic's policy.

On a personal note, being awarded this fellowship caused real tension between myself and the senior health adviser who I believed sought to block my taking it up, but he was overruled by the senior consultant in the clinic who approved my study leave to undertake the project. This episode exacerbated existing tensions between myself and my senior, who did not have a professional qualification and thus was ineligible for such opportunities, and who from my perspective had a rather negative attitude towards research and professional development for health advisers.

An Occupation in Transition

At the time I was working as one in the mid-1980s, sexual health advising was an occupation in transition, seeking to be recognised as a distinct profession. Sexual health advisers were and are one of many smaller occupational groups in the NHS seeking professional status.[29] Health advising in the 1980s lacked some attributes of a profession (e.g. formalised training, competitive examinations, registration) but colleagues

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[28] Kevin Fenton, *et al.*, 'HIV Partner Notification Policy and Practice Within GUM Clinics in England: Where Are We Now?', *Genitourinary Medicine* 1997, 73, 49–53.

[29] Evans, 'Initially This Work Was Done by Doctors'.

were seeking others, in particular through the establishment of a professional organisation, the Society of Health Advisers in Sexually Transmitted Diseases (SHASTD), later the Society of Sexual Health Advisers (SSHA).[30]

Sexual health advisers' ambiguous professional position was illustrated in a number of ways by mainly unspoken but deeply hierarchical structures and rules of the clinic. Most tellingly, consultants were always referred to as 'Dr [Surname]', whilst junior doctors, health advisers, nurses and receptionists were generally referred to by their first names. Doctors and health advisers wore white coats over their ordinary clothes, whilst nurses were in uniform. (After a few months in post, my female colleague shocked the clinic by ditching her white coat which was of course unnecessary for hygiene purposes as we did not undertake clinical procedures, so as to be less daunting to patients; I followed suit shortly afterwards and felt more comfortable though I was not sure whether it impacted on the degree of contact information I managed to obtain from patients.) Consultants had access to a consultants' dining room in the hospital, whilst other staff (administrators, health advisers, junior doctors, nurses) generally ate in the clinic staff room. Consultants and junior doctors were involved in medical education and training, time away from the clinic which was opaque to other staff. Training opportunities were much more limited for health advisers and nurses. And consultants were involved in the appointment of all other staff, but no other staff were involved in the appointment of consultants.

At the time I was working there, none of the GUM consultants in the Bristol clinic had an honorary university appointment (although a new consultant was appointed shortly after I left who did), but more widely, research in GUM was largely conducted by medical doctors with academic links. I knew of no research active or academically based health advisers or publications by health advisers. Thus, unlike other health professions, sexual health advisers lacked an academic base to underpin our claims to expert professional knowledge. Personally, I was keen to be involved in research but other than my HIV/AIDS fellowship, no further opportunities presented themselves within the clinic. More for the intellectual stimulation than any career planning, I then commenced a part-time evening Masters in Historical Studies, and choose to do my dissertation on the origins of the system of VD clinics in early twentieth-century Britain. This I adapted into my first peer-reviewed publication and it later proved to be crucial in my obtaining my first academic post.[31]

The one most significant professional training opportunity I attended was an annual SHASTD conference. My memory is that there were 2 days of presentations covering practical aspects of both the traditional STI work and HIV counselling. But what I most remember was the conference dinner which forcefully illustrated the nature of an occupation seeking to professionalise. First, I was struck by what appeared to be a quite distinct division between older and younger sexual health advisers. Although both older and younger health advisers usually came from either nursing or social work

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[30] Society of Sexual Health Advisers, *The Manual for Sexual Health Advisers* (London: Society for Sexual Health Advisers, 2004).

[31] David Evans, 'Tackling the 'Hideous Scourge': The Creation of the Venereal Disease Treatment Centres in Early Twentieth Century Britain', *Social History of Medicine*, 1992, 5, 413-433.

backgrounds, the older ones dressed more conservatively and from what I could gather, generally did not have university degrees. The younger ones were much more casually dressed, often in jeans and tee-shirts, and often had a social science degree as well as their professional qualification. The divide was most vividly displayed when the honorary president, an older GUM consultant, rose at the end of the dinner to propose a toast to the queen. Older colleagues, who had clearly experienced this at previous conferences, rose to join the toast. This took the younger members by surprise, and many remained seated, due possibly to a combination of republican sentiments and a feeling of incredulity of such formality and hierarchy in the professional society they had recently joined, often in response to the HIV/AIDS pandemic. The very fact that we had a medical consultant rather than a health adviser colleague as president illustrated to me the embryonic nature of our professional aspirations at the time. I later heard from another health adviser working in the 1990s that by that point the Society no longer had a GUM consultant as president.

Health advisers' ambiguous professional status was also illustrated by the lack of specific qualifications required in job descriptions, the diversity of educational backgrounds of health advisers and the varied gradings of posts, exemplified by my own experience of being appointed on an administrative grade but later regraded to a higher nursing grade.

Finally, we as an aspirant profession lacked a coherent and consistent body of knowledge on which to base our claims to professional expertise, particularly around our traditional role of contact tracing. A key experience that demonstrated to me the professional transition underway concerned our practice of calling health advisers in other GUM clinics to ask them to pursue STI contacts in their areas named by our patients. Over my time in the clinic, these requests were met with increasing resistance, and in the case of London, often with disbelief. In London in particular, the culture of active contact tracing for STIs in the community seemed to have been largely abandoned as health advisers focused on their role in HIV counselling.

There appeared to be several arguments against contact tracing. One was an ethical concern that it infringed the rights to privacy and risked the confidentiality of the index patient. Second, that it depended on a coercive approach to extracting information from the index patient. Finally, that there was little evidence it was effective or cost effective; there were very few evaluative studies of contact tracing for traditional STIs in the UK or internationally, and many of the published studies were descriptive and of limited value in assessing effectiveness.[32] Looking back I think this was a moment of profound cultural change within the occupational group, with a questioning of traditional contact tracing practices, an embracing of a non-directive empowerment model of practice drawn from the HIV voluntary sector and a generational shift in the academic backgrounds of new entrants into the role.

[32] Frances Cowan, Rebecca French and Anne Johnson, 'The Role and Effectiveness of Partner Notification in STD Control: A Review', *Genitourinary Medicine*, 1996, 72, 247–252.

Regrading and Moving On

In the middle of my second year, there was a major national regrading exercise for NHS nurses, midwives and health visitors,[33] which I and my female colleague realised could apply to us. We were both on a relatively low administrative grade which was unusual for staff with direct patient contact, particularly for those working independently in the community as we were. Even more unusually, we were running clinics and seeing patients, and giving diagnostic results for a serious health condition, without direct medical supervision. As we were both qualified general nurses and had kept our nursing registration up-to-date, we realised we could make a case for equivalence with other nursing staff such as health visitors who worked independently in the community. Despite lack of support from the senior health adviser, we applied. Somewhat to our surprise, and to our delight, we were successful and given a G grade, which was the grade normally given to ward sisters and health visitors. I personally did not benefit significantly, as I had already decided to leave and had secured a post in the health authority's health promotion unit, but it did benefit my female colleague. I suspect it must have presented a problem to the hospital management, as it was likely to have meant that my colleague was then on a higher pay scale than the senior health adviser who was her superior in the formal hierarchy.

I left my post as health adviser after 2 years for both positive and negative reasons to take up a post working on HIV and sexual health in the health promotion unit attached to the health authority's public health department. Negatively, I found the role of HIV counselling too stressful at a time there was no treatment for HIV or AIDS, and giving a positive test result felt like giving a death sentence. I was also increasingly unhappy working to a senior health adviser whose practice I increasingly questioned, and who I did not feel was supportive of my professional development. Lastly, I was ready to move out of a clinical environment which remained stubbornly hierarchical, even though as a health adviser I stood somewhat outside the strict medical and nursing hierarchies that dominated the clinic. Positively, I had started to contribute some HIV input into health professional training programmes, and I found I enjoyed an educational role. More fundamentally, it felt more useful to be working on preventing the spread of HIV rather than testing people for it.

Conclusions

As I acknowledged in the Introduction, this is a single subjective account based on my selective and potentially unreliable memories of work I was engaged in nearly four decades ago. Nonetheless, in the absence of other accounts, I would argue that it provides a valuable point of access into important but otherwise little-known aspects of the history of UK sexual health services.

Looking back after 35 years of working in both service and academic public health, I am struck by four main reflections. First, it was extraordinary how poorly prepared I was to take on such a sensitive role. I had very little induction or formal training for either the

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[33] Department of Health and Social Security, *New Clinical Grading Structure for Nurses, Midwives and Health Visitors—Implementation Guidance* (London: Department of Health and Social Security, 1988).

traditional STI or the HIV work. I had no preparation for issues of safeguarding underage or otherwise vulnerable clients, nothing on consent to sex, domestic violence or sexual violence. As I progressed in the role, I had minimal supervision, there were no multidisciplinary team meetings to discuss difficult cases or issues, no expectation of continuing professional development or audit. Similarly, there was no consideration for the impact of our work on our own health and wellbeing, no formal system of annual appraisal or professional development review (PDR). By contrast, when working in health promotion and later in public health in various NHS bodies, there was always a management commitment to annual PDR. Indeed, evidence of continuing professional development (CPD), was and is a requirement for registration with regulatory bodies like the UK Public Health Register (UKPHR) and the professional body, the Faculty of Public Health (FPH).

Second, my experience contributes in a small way to surfacing the complex racial dynamics of working in a STI service in a multicultural society and the failure at the time for services to seriously engage with questions of race inequality and institutional and individual racism. In retrospect it was extraordinary to be thrown into a role with complex racial dimensions with no relevant training or discussion within the service. Anne Hanley has examined racism in sexual health services in postwar Britain, but her account is focused on the period up to the early 1960s prior to the emergence of the modern sexual health adviser.[34] Thus, it would be useful to extend the history of race and racism in sexual health services to the later twentieth century, and, in particular, to have other health advisers' accounts on the extent to which they encountered and addressed issues of race and racism in their own services. Although almost certainly more challenging to obtain, hearing the accounts of Black and other ethnic minority users of sexual health services would be vital to critically exploring this history.[35]

Third, although I did not fully recognise it at the time, I did use the power imbalance of being a professional in a clinic to pressurise some patients into revealing more about their sexual contacts than they wished to.[36] There was no overt coercion, but I did press them even after they had initially indicated a desire not to share their contacts information. In many cases, they were in a vulnerable place having just experienced a genital examination and being taken through a series of encounters with health professionals where they were generally expected to be passively compliant with everything the clinic asked them to do. I did this with an assumption shared with other clinic staff that halting the transmission of a STI was more important than the autonomy and freedom to

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[34] Hanley, 'Migration, Racism and Sexual Health in Postwar Britain'.

[35] Hanley has identified the absence of Black service user voices in the archives and the need for historians to find new ways of addressing this gap: Hanley, 'Migration, Racism and Sexual Health in Postwar Britain', 216.

[36] The nature of the power inequality between health professionals and patients in the clinic has been the subject of scholarly debate since Talcot Parsons' concept of the 'sick role' in the 1950s, but especially since the work of Michel Foucault on the 'medical gaze' in the 1960s: Talcot Parsons, *The Social System* (Glencoe, Illinois: Free Press, 1951); Michel Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception* (London: Tavistock, 1973). More recent work has emphasised the importance of a more nuanced exploration of evidence for patient agency. See Anne Hanley and Jessica Meyer, eds, *Patient Voices in Britain, 1840-1948* (Manchester: Manchester University Press, 2021) and, especially relevant in this context, Anne Hanley, "I Caught It and Yours Truly Was Very Sorry for Himself': Mapping the Emotional Worlds of British VD Patients', in Anne Hanley and Jessica Meyer, eds, *Patient Voices in Britain, 1840-1948 (Manchester: Manchester University Press, 2021)*, 299–337.

choose of the patient. Ultimately, patients did have a choice and a number of them exercised it to refuse to see the health adviser or choose not to reveal their sexual contacts. But this does not take away from the reality that I and other health advisers sought to use the power of the clinic to override the freedom of choice of patients not to name their contacts. This of course has been and remains a central ethical issue in public health—to what extent and in what circumstances is it ethical to restrict the freedom of some individuals to protect the wider public from harm?[37] Hanley and other historians have critiqued UK sexual health services for such hidden forms of coercion and surveillance earlier in the twentieth century.[38] Again, it would be extremely useful to have more health adviser narratives on how they understood and managed such ethical dilemmas in practice in the later part of the century, and service user voices on how they experienced these encounters.

Fourth, my personal experience illustrates the state of play in the mid-1980s of the professionalising project of sexual health advisers that I have written about elsewhere.[39] I did not fully understand it at the time, but I knew I worked in a very hierarchical institution where doctors were the most powerful profession. I also knew that professional registration was important, and had experienced myself the career enhancement of having a professional registration as a nurse as well as a degree. I would not have got my health adviser post, my HIV fellowship or my health promotion post without my nursing registration. But I did not then understand the many hidden structures that underpinned the hierarchy within health care, and the systems of training, examinations, registration, regulation and professional bodies like the medical royal colleges than buttressed medicine at the top of the professional hierarchy. Neither did I have a theoretical understanding; that came later when I was part of the movement to open up senior public health posts to disciplines other than medicine, and began to read and apply the sociology of the professions to public health. In particular, the work of Eliot Freidson, and Magali Larson on the sociology of medicine as a profession enabled me to apply the concept of the professional project to public health doctors' resistance to multidisciplinary public health.[40] The same concept of the professional project has helpfully informed my recent work on the history of sexual health advisers in England over the twentieth century.[41]

Finally, I recognise that I have shared this account from the privileged position of a White, male, middle-class health professional during the period in question and an academic at the time of writing. My account is singular and subjective, and will have been shaped by unconscious bias from my privileged position; but I believe it raises a

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[37] Nuffield Council on Bioethics, *Public Health: Ethical Issues* (London: Nuffield Council on Bioethics, 2007).

[38] Hanley, 'Migration, Racism and Sexual Health in Postwar Britain'; Pamela Cox, 'Compulsion, Voluntarism, and Venereal Disease: Governing Sexual Health in England After the Contagious Diseases Acts', *Journal of British Studies*, 2007, 46, 91–115; Samantha Caslin, 'Transience, Class and Gender in Interwar Sexual Health Policy: The Case of the Liverpool VD Scheme', *Social History of Medicine*, 2019, 32, 544–564.

[39] Evans, 'Initially This Work Was Done by Doctors'.

[40] Eliot Freidson, *Profession of Medicine: A Study of the Sociology of Applied Knowledge* (New York: Dodd, Mead & Co, 1970); Magali Larson, *The Rise of Professionalism: A Sociological Analysis* (Berkeley: University of California Press, 1977); David Evans, 'Taking Public Health Out of the Ghetto': The Policy and Practice of Multi-disciplinary Public Health in the UK NHS', *Social Science & Medicine*, 57, 959–967.

[41] Evans, 'Initially This Work Was Done by Doctors'.

number of important issues which it would be useful to explore through further narrative accounts of other health advisers’ experiences to identify both any common themes and areas of contestation. Most importantly, as Hanley has argued, such accounts need to be balanced with narratives by service users (particularly those from Black and other marginalised communities), whose crucial voices are almost entirely unheard in the historical literature on sexual health services to date.[42]

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[42] Hanley, “I Caught It and Yours Truly Was Very Sorry for Himself’; Hanley, ‘Migration, Racism and Sexual Health in Postwar Britain’.