

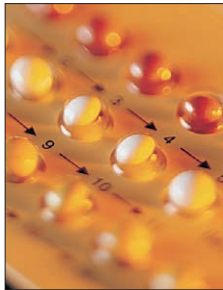
Ethical behaviour too is a responsibility of medical journals whose goal should be truth and objectivity. Articles such as this one lead us to believe that *The Lancet* has strayed off course.

I declare that I have no conflict of interest.

David N Tornberg  
david.tornberg@tma.osd.mil

TRICARE Management Activity, Office of the Assistant Secretary of Defense For Health Affairs, Suite 810, 5111 Leesbury Pike, Falls Church, VA 22041, USA.

- 1 Wilks M. A stain on medical ethics. *Lancet* 2005; **366**: 429–31.



## Missed contraceptive pill recommendations

We appreciate the interest shown by Diana Mansour and Ian Fraser (May 14, p 1670)<sup>1</sup> in our statement<sup>2</sup> on the WHO “missed pill” recommendations.<sup>3</sup> Our Clinical Effectiveness Unit provides objective statements on new publications in the field of contraception to assist members of the UK Faculty of Family Planning and Reproductive Health Care in their decisions about adopting new evidence into practice. Mansour and Fraser make a number of criticisms about our statement.

First, they question the ability of pill users to interpret and apply the new missed pill rules. Our unit’s guidance is aimed at family planning clinicians, rather than contraceptive users. Although we assume that most women know the name and type of their pill and would be able to apply the recommendations, our statement was designed for clinicians rather than patients. The fpa (formerly the Family Planning Association) has published the same information in a format designed for women.

Second, Mansour and Fraser judge it better to have one rule for all combined pills than to have different rules for pills containing different doses of ethinylestradiol. This would mean adopting the most cautious approach for all. Many more women would have

to use additional contraception for 7 days, omit the pill-free interval, and consider emergency contraception. The WHO recommendations minimise intervention and inconvenience for the maximum number of women.

Third, they criticise our lack of definition of a “missed” pill (they assume we refer to a pill delayed more than 12 h after the scheduled time). We concede that we did not provide an explicit definition; neither did the WHO source document.<sup>3</sup> We regard a pill as “missed” (rather than “late”) only when 24 h have elapsed after the scheduled time.

Fourth, Mansour and Fraser think we are insufficiently cautious about extending the pill-free interval beyond 7 days. Of the three studies they cite in support of their concerns, two were published after the WHO recommendations were developed.<sup>4,5</sup> The first confirms that method failures occur in combined pill users, but not that failures are related to the pill-free interval.<sup>4</sup> The second confirms follicular development, but not ovulation, during a 7-day pill-free interval;<sup>5</sup> it provides no information on the effects of extending the interval. WHO recommends precautionary measures when the pill-free interval is extended to 9 days; we stand by these recommendations, which are based on previously published evidence.

Finally, the commentators advise caution before relaxing rules in litigious societies. It is central to the philosophy of the Faculty of Family Planning and Reproductive Health Care that practice is based on evidence, not on fear of litigation. We believe that the missed pill rules developed by WHO and endorsed in our statement are evidence-based. Practitioners wishing to minimise interventions for women who have missed pills (in the interests of patients’ convenience and conservation of resources) should feel protected against the threat of litigation by these recommendations from respected organisations.

We declare that we have no conflict of interest.

\*Gillian Penney, Susan Brechin, Anna Glasier, Alison Bigrigg  
g.c.penney@abdn.ac.uk

Director (GP) and Co-ordinator (SB), Faculty of Family Planning and Reproductive Health Care (FFPRHC) Clinical Effectiveness Unit, Royal College of Obstetricians and Gynaecologists, 27 Sussex Place, London NW1 4RG, UK; Chair, FFPRHC Clinical Effectiveness Committee (AG); and President, FFPRHC (AB).

- 1 Mansour D, Fraser IS. Missed contraceptive pills and the critical pill-free interval. *Lancet* 2005; **365**: 1670–71.
- 2 Faculty of Family Planning and Reproductive Health Care. Missed pills: new recommendations. *J Fam Plann Reprod Health Care* 2005; **31**: 153–55.
- 3 World Health Organization. Selected practice recommendations for contraceptive use, 2nd edn. Geneva: WHO, 2004. [http://www.who.int/reproductive-health/publications/rhr\\_02\\_7/](http://www.who.int/reproductive-health/publications/rhr_02_7/) (accessed Aug 25, 2005)
- 4 Trussell J. Contraceptive failure in the United States. *Contraception* 2004; **70**: 89–96.
- 5 Baerwald AR, Olatunbosun OA, Pierson RA. Ovarian follicular development is initiated during the hormone-free interval of oral contraceptive use. *Contraception* 2004; **70**: 371–77.

## Prostitutes are people too

Stephen Due (July 9, p 121)<sup>1</sup> insists that prostitution is an “evil” which must be abolished, and chastises *The Lancet* for its “morally neutral tone” with regard to prostitution.<sup>2</sup> We commend *The Lancet* for its frank and humane position,<sup>2</sup> and believe that Due reflects a position of repression, which often aggravates the problem, creating major barriers to meeting the health and social needs of prostitutes.

Due cites violence, organised crime, drugs, and human trafficking as among the reasons for campaigning against prostitution. However, prostitutes themselves do not cause these social ills, but become their victims. Irrespective of whether we regard it as desirable or not, sexual behaviour between consenting adults is not a moral crime, nor does it violate basic principles of ethical behaviour.

So long as there is a perception of social derogation of any group of

people, which is often reinforced by legislation, such people are marginalised and endangered. It is our historical treatment of prostitutes that has made them vulnerable to violence and abuse.

Criminalising prostitution denies people, in this case mainly women, choices and the right to control their own bodies. There has been debate as to whether prostitutes have choices; our duty is to increase their relatively few options, not reduce them further.

It is abuse of human beings, no matter what their occupation, that must be combated. The “evil” that Due points to consists of activities that are crimes and morally and ethically unacceptable in any walk of life, and we are bound to apply the protections of society from abuse to every person equally.

Health professionals have to adopt morally neutral positions if they are to work with and help every member of society equally. Whether abolition of prostitution is a realistic or desirable goal is irrelevant to a duty, collectively and individually, to care for prostitutes. Due’s position is an example of confusing morals with ethics. *The Lancet* is correct in stating that the health profession’s ethic mandates the protection of the vulnerable, and that only by providing them the full protection of the law and the resources of our society will that mandate be fulfilled.

Prostitutes are a group of people who have greater than average health and social needs and the health professions have, by and large, failed them abysmally. *The Lancet* joins other medical journals such as the *CMAJ*<sup>3</sup> and criminologists<sup>4</sup> in calling for the decriminalisation and protection of prostitutes. As one of us has stated, “the criminal law is a rather ineffective custodian of moral norms, especially when these are disobeyed by many and disagreed with by many more”.<sup>5</sup> Only by making our society completely inclusive will we achieve true distributive justice. Prostitutes are

indeed people too, with real needs. If we forget this fact, we betray our commitment to caring.

We declare that we have no conflict of interest.

\*Michael Goodyear, John Lowman, Benedikt Fischer, Margie Green  
mgoodyear@dal.ca

\*Faculty of Medicine, Dalhousie University, 1278 Tower Road, Halifax, Nova Scotia B3H 2Y9, Canada (MiG); School of Criminology, Simon Fraser University, Burnaby, British Columbia, Canada (JL); Department of Public Health Sciences and Centre of Criminology, University of Toronto, Toronto, Ontario, Canada (BF); and Sex Worker, Halifax, Nova Scotia, Canada (MaG)

- 1 Due S. Prostitution and health. *Lancet* 2005; **366**: 121–22.
- 2 The Lancet. Prostitutes are people too. *Lancet* 2005; **365**: 1598.
- 3 Canadian Medical Association Journal. Prostitution laws: health risks and hypocrisy. *CMAJ* 2004; **171**: 109.
- 4 Lowman J. Reconvening the federal committee on prostitution law reform. *CMAJ* 2004; **171**: 147.
- 5 Fischer B. Dealing with prostitution in Canada. *CMAJ* 2005; **172**: 13.

## Screening for oral cancer

Deciding whether an oral cancer screening programme should be established depends on the balance between the potential benefits of screening in terms of improved outcome for patients, the harms of screening resulting from testing and investigating the healthy population, and the resources required. Publication of the final round of the only randomised controlled trial (RCT) on oral cancer screening (June 4, p 1927)<sup>1</sup> provides fair evidence for its effectiveness in high-risk populations in India, where oral cancer is one of the most common forms of malignant disease. However, we have identified some methodological weaknesses in Rengaswamy Sankaranarayanan and colleagues’ RCT according to the high standards of the Cochrane Collaboration and the CONSORT statement on cluster randomised trials.<sup>2,3</sup>

These weaknesses include lack of allocation concealment and the small number of clusters randomised, which increases the potential for imbalance

across treatment groups; indeed, Sankaranarayanan and colleagues themselves recognise that variations in risk factors at baseline were confounding to some extent. In addition, the close geographical proximity of the clusters could lead to contamination. No data were provided on quality of life, costs, or lead time that can result in length bias. Some assumptions seem to have been made about the sensitivity and specificity of the screening test itself and it seems that the ability of the health workers to discriminate significant oral lesions was not measured.

More importantly for decision makers, there was no hard information on the harms of screening. In particular, no data were provided for the overall specificity of the programme. False-positive screening can cause distress, and unnecessary investigations can be a huge drain on scarce resources. The number of false-positive screens tends to increase as the prevalence of the disorder in the population decreases, so if false-positive rates were high in Kerala, it could be a major consideration for those planning trials in populations where oral cancer is less prevalent.

Lessons from existing screening programmes should be taken into account when planning future trials. In cervical cancer screening programmes, adjunctive methods to visual examination have proved pivotal for detection of early lesions using risk markers. More research is needed to understand the natural history of oral cancer at the molecular level, and to develop objective clinical methods for identification of early oral lesions.

The results of Sankaranarayanan and colleagues’ study do not change the conclusion of our earlier Cochrane review<sup>2</sup> that there is insufficient evidence to support or refute the introduction of population-based screening programmes for oral cancer worldwide. However, theirs is an invaluable contribution nevertheless and should stimulate further oral cancer screening

