

them. However, when we develop knowledge, our moral responsibility grows in proportion to our capacity to control disease and death. Once we gain a certain level of mastery, we bear responsibility for the consequences our actions have on patterns of human health.² This simple but compelling moral standpoint is what leads us to prefer relative over absolute measures in the situation we studied.³

To understand, imagine a circumstance in which mortality rates for a disease are declining precipitously as a result of an advance in human knowledge. Imagine also that the absolute gap between an advantaged and a disadvantaged group remains constant over time. According to our moral argument, a gap of the same magnitude becomes more problematic as we gain control over the disease—it is more completely our responsibility. An absolute measure (rate difference) fails to reflect this moral position, suggesting instead that health inequalities remained constant over time. A relative measure, by contrast, coheres with our moral stance by showing a growing rate ratio over time. It correctly indicates that an absolute gap of the same magnitude becomes more morally reprehensible as we gain control.

King et al. have done us a service by identifying problems in the interface between measures of health inequality and the moral and ethical issues that surround them. However, we found little guidance in their statements with respect to how to move toward solutions to the philosophical issues they identify, thereby necessitating a very modest de novo attempt on our part. Thus, while King et al.'s insights have utility for identifying problems and thereby facilitating a kind of policing of health inequalities researchers to ensure acknowledgment of those problems, providing a well-reasoned set of ethical principles connected to these problems is an issue that still lies before us. ■

Marcie S. Rubin, MPH, MPA
Cynthia G. Colen, PhD
Bruce G. Link, PhD

About the Authors

Marcie S. Rubin is with the Department of Sociomedical Sciences, Mailman School of Public Health, Columbia

University, New York, NY. Cynthia G. Colen is with the Department of Sociology and the Initiative for Population Research, the Ohio State University, Columbus. Bruce G. Link is with the Department of Epidemiology, Mailman School of Public Health, Columbia University, New York, and the New York State Psychiatric Institute, New York.

Correspondence should be sent to Bruce G. Link, Department of Epidemiology, Columbia University, 722 West 168th Street, Room 1609, New York, NY 10032 (e-mail: bgl1@columbia.edu). Reprints can be ordered at <http://www.ajph.org> by clicking the "Reprints/Eprints" link.

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Contributors

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WE NEED DATA ON ANAL SCREENING EFFECTIVENESS BEFORE FOCUSING ON INCREASING IT

We are concerned that the article by Reed et al. on gay and bisexual men's willingness to receive anal Papanicolaou (Pap) screening¹ perpetuates the belief that such screening has been shown to be effective. This is not the case. No prospective studies have demonstrated that performance of anal screening reduces the incidence of invasive anal cancer or of death as a result of cancer.² The authors' statement that "it is promising that potential benefits of anal cancer screening for gay and bisexual men are comparable to observed benefits of cervical cancer screening for women"^{1(p1127)} is tautological. Because the effectiveness of anal screening in gay and bisexual men is unknown, the two cited analyses^{3,4} assume that the effectiveness of treating lesions found using anal screening in men is similar to that of treating lesions found by using cervical screening in women.

It is certainly possible that anal screening with Pap smears is an effective method of reducing invasive cancer. However, given

the cost, the anxiety experienced by patients told that they have an abnormal anal Pap, and the discomfort caused by the treatment of lesions found through anal screening, the practice needs to be proven effective before we focus on encouraging more people to be tested.⁵ We should not advocate for spending scarce health dollars on medical procedures of no proven effectiveness when there are so many proven interventions that are not available to all who need them. ■

Mitchell H. Katz, MD

Kenneth A. Katz, MD, MSc, MSCE

Kyle T. Bernestein, PhD, ScM

Jeffrey D. Klausner, MD, MPH

About the Authors

Mitchell H. Katz and Kyle T. Bernestein are with the Department of Public Health, San Francisco, CA. Kenneth A. Katz is with the Health and Human Services Agency, County of San Diego, San Diego, CA. Jeffrey D. Klausner is with the Department of Medicine, University of California, San Francisco.

Correspondence should be sent to Mitchell H. Katz, MD, 101 Grove Street, Room 308, San Francisco, CA 94101 (e-mail: mitch.katz@sfdph.org). Reprints can be ordered at <http://www.ajph.org> by clicking the "Reprints/Eprints" link.

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Contributors

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