

software. The fact that no decision model was created, and that no computerized software was used for the critical parts of the analysis, leads me to question the accuracy and validity of this cost-benefit analysis. It might instead be "one clinic's accounting of treatment costs for the treatment of an abnormal Papanicolaou smear."

As researchers in family medicine, it is important that we maintain rigorous scientific methodology to answer our important questions. We must be specific about the methodology we are using, and we must not borrow concepts from fields without a full understanding of their implications.

Diane M. Harper, MD, MPH
Dartmouth Medical School
Hanover, NH

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In reply

We appreciate Dr Harper's in-depth analysis and critique of our work. We agree that there are standards for cost-effectiveness studies and that the book *Cost-Effectiveness in Health and Medicine* is an excellent reference.¹ We did not use the term cost-effectiveness in our title because, according to the *Journal of the American Medical Association* glossary of methodological terms, cost-effectiveness analysis involves a comparison of alternative programs, services, or interventions. We did not compare alternative strategies and believe our work better fits the definition of cost-benefit analysis.² The only cost-effectiveness study we are aware of that compares different interventions in the evaluation of squamous intraepithelial lesions (SILs) on Papanicolaou smear results was written by Roland et al.³ They presented a decision model and found little difference in the cost of different treatment strategies. It was not our goal to compare different treatment strategies. We were interested in determining whether colposcopy performed on low-grade SILs in our patient population was an efficient use of health care resources.

We were not as explicit as we might have been about detailing the cost for several reasons. We were most interested in the cost-benefit ratio of evaluating a low-grade vs a high-grade SIL on a Papanicolaou smear result. We were not so interested in the absolute cost number but rather the magnitude of the differences in the costs. We used the payer perspective. A societal perspective would include the additional lost wages incurred by keeping appointments. Because our patient population is mostly unemployed, the additional \$4.79 per hour (average wage of a child care worker in Alabama) would not substantially change our analysis.⁴

We were surprised to learn from our analysis that going directly to colposcopy in response to a low-grade SIL was justified. We had been fully prepared to discover that the health benefit of evaluating a low-grade SIL with colposcopy was too small to justify the cost and were careful not to overload the analysis with costs that were not clearly justifiable.

The question of a 3% vs a 5% discount rate is an intriguing philosophical question. We chose 5% for several reasons: it is the most commonly used discount rate in the medical literature, the Centers for Disease Control and Prevention recommend it, and it is in accordance with the rate used by Weinstein et al,⁵ one of our references. The referenced book by Gold et al devotes quite a few pages to discussing the choice of discount rates, and interested readers are encouraged to read it.¹

We appreciate Dr Harper's remarks and have to agree with her that our study and others have not settled these issues.

Marcia J. Chesebro, MD
W. Douglas Everett, MD, MPH
University of Alabama
School of Medicine—Huntsville Program

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5. Weinstein MC, Fineburg HV, Elstein AS, et al, eds. *Clinical Decision Analysis*. Philadelphia, Pa: WB Saunders Co; 1980.