

students' empathy for the less fortunate comes from their own experience of socioeconomic disadvantage. We then consider SES, rather than race, to be the legitimate factor to evaluate in determining who has experienced disadvantage and who is likely to serve the underserved. It makes more sense and feels more comfortable.

Studies of service commitment, however, have shown that, compared with race, SES is a relatively weak predictor of medical students' going on to serve the underserved. In fact, URM students from the *highest* SES categories serve the underserved at greater rates than do white students from the *lowest* SES groups.<sup>3</sup> One possible reason for this finding is that SES changes over time, while race does not. In becoming a physician, a student from a poor or working-class upbringing moves quickly into a higher social tier and is no longer a member of a disadvantaged class. Race, however, confers more durable disadvantage. Underrepresented minority students and physicians, regardless of SES, do not escape the experience of discrimination, negative stereotyping, and exclusion. They must continuously deal with the unfairness of a racial hierarchy that, although officially abolished, remains deeply embedded in our social fabric and unconscious attitudes.

The increasing health care needs of our aging population and the expansion of health insurance coverage to previously uninsured Americans have prompted efforts to rapidly augment our physician workforce. Simply training more physicians, however, will not meet our needs. We should be deliberately selecting and training physicians who will go into undersupplied specialties (eg, primary care), serve vulnerable patient populations (eg, the poor and disabled), and practice in underserved communities (eg, inner-city and rural areas). Meeting these needs will require a strategic approach. One important and evidence-based strategy is to train more URM physicians. Underrepresented minority status is more predictive of serving the underserved than SES, rural or urban upbringing, or participation in the National Health Service Corps, a federal program providing financial incentives for health professionals to work in underserved areas.<sup>3</sup> Increasing URM representation in medicine will not only help meet our public health needs but will also have the added benefits of producing a more robust learning environment in medical schools, as well as a more trustworthy and culturally competent physician workforce. Perhaps most important, it will fulfill our moral obligation to address the injustices that made URM groups underrepresented in the first place.

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1. Saha S, Guiton G, Wimmers PF, Wilkerson L. Student body racial and ethnic composition and diversity-related outcomes in US medical schools. *JAMA*. 2008;300(10):1135-1145.
2. Saha S, Shipman S. *The Rationale for Diversity in the Health Professions: A Review of the Evidence*. Washington, DC: Health Resources & Services Administration, US Dept of Health & Human Services; October 2006.
3. Saha S, Shipman SA. Race-neutral versus race-conscious workforce policy to improve access to care. *Health Aff (Millwood)*. 2008;27(1):234-245.
4. Moy E, Bartman BA. Physician race and care of minority and medically indigent patients. *JAMA*. 1995;273(19):1515-1520.
5. Marrast LM, Zallman L, Woolhandler S, Bor DH, McCormick D. Minority physicians' role in the care of underserved patients: diversifying the physician workforce may be key in addressing health disparities. *JAMA Intern Med*. doi:10.1001/jamainternmed.2013.12756.

**RESEARCH LETTER**

**Availability of Consumer Prices From Philadelphia Area Hospitals for Common Services: Electrocardiograms vs Parking**

Most people in the United States are shielded by third-party payers from the marginal cost of their health care consumption. It has been suggested that removing that shield would foment concern about price and, in turn, create market pressure to keep prices down.

Nevertheless, however concerned about prices they may be, consumers cannot act on their concerns if prices are not easily available. This point was raised by Rosenthal et al,<sup>1</sup> who

**Table. Price Information for the Cost of Electrocardiograms (ECGs) and Parking**

Hospital No.	Price, \$	
	ECG	Parking
1	NP	-6 for 2 h, discounted
2	NP	NP
3	137	0
4	NP	0
5	NP	0
6	NP	0
7	1200	-15 for 2-3 h, discounted
8	NP	-15 for 2-3 h, discounted
9	NP	0
10	NP	0 for visitors
11	NP	0
12	NP	0 for visitors
13	NP	0 for visitors
14	NP	0 for visitors
15	600	0
16	NP	0
17	NP	0 for 30 min; 3 for 2-3 h, discounted
18	NP	2 for visitors with validation
19	NP	0
20	NP	3 for 1 h; 5 for 2-5 h

Abbreviation: NP, not provided.

attempted to find the price for hip replacement and discovered that “many health care providers cannot provide reasonable price estimates.”

Still, it may be incorrect to extrapolate the findings of Rosenthal et al<sup>1</sup> to all health care because hip replacement is a complex service. The price of a hip replacement may not be known in advance because costs are higher if a special implant will be needed or if the patient requires a prolonged hospital stay. Furthermore, even if hospitals know their typical cost, they may find it unwise to offer hip replacements at that figure. Owing to information asymmetry,<sup>2</sup> hospitals selling hip replacements to all comers at their typical cost might find themselves inundated with patients who suspect that their own costs will be higher.

It also may be the case that hospitals are ill equipped to answer questions about price over the telephone.

To test these hypotheses, the methods of Rosenthal et al<sup>1</sup> were used with a variation. We telephoned and asked whether price information could be obtained for an electrocardiogram (ECG)—a procedure with uniform costs and free of adverse selection. Next, we telephoned and asked whether price information could be obtained for the cost of parking at the hospital. The provision of parking prices would suggest that hospitals can indeed answer telephone queries about costs—when they want to.

**Methods** | Twenty hospitals in the Philadelphia, Pennsylvania, area were telephoned by one of us (J.R.H.B.). After connection to the appropriate department, the investigator attempted to determine the price of an ECG; the investigator indicated that she had no health insurance and would like to pay cash. For each facility, the investigator recorded the price or noted that a price was not provided. A second call was then placed by the investigator, who indicated that she was coming for an ECG and wanted to know the cost of parking at the facility. The response to that query was recorded as well.

The City of Philadelphia institutional review boards determined that formal review and approval of this study was not required.

**Results** | Among the 20 hospitals contacted, a price for an ECG could be obtained from only 3 (Table). Information about the cost of parking was available from 19. Of these, 10 offered either free or discounted parking for visitors.

**Discussion** | In response to a telephone query, price information for ECGs—a simple and uniform medical service—was provided by only 3 of 20 area hospitals. This finding goes beyond that of Rosenthal et al<sup>1</sup> because they investigated a complex medical service for which failure to provide a price in advance may be more reasonable.

We also discovered that hospitals almost invariably could provide the price of parking and that parking was often discounted. This demonstrates not only that hospitals are able to provide cost information by telephone but, we infer, that they can respond to consumers' concern about cost.

In short, the findings of Rosenthal et al<sup>1</sup> were confirmed and indeed strengthened. Hospitals seem able to provide prices when they want to; yet for even basic medical services, prices remain opaque. Accordingly, medical insurance payment schemes that promote concern about prices without a commensurate increase in price transparency are apt to be ineffective.

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*Study concept and design:* J. Bernstein.

*Acquisition of data:* J. R. H. Bernstein.

*Drafting of the manuscript:* J. Bernstein.

*Critical revision of the manuscript for important intellectual content:* J. R. H. Bernstein.

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1. Rosenthal JA, Lu X, Cram P. Availability of consumer prices from US hospitals for a common surgical procedure. *JAMA Intern Med.* 2013;173(6):427-432.
2. Akerlof GA. The market for “lemons”: quality uncertainty and the market mechanism. *Q J Econ.* 1970;84(3):488-500.

## Overuse of Papanicolaou Testing Among Older Women and Among Women Without a Cervix

Leading national organizations are increasingly using evidence-based recommendations for Papanicolaou testing. As of 2003, organizations recommended against Papanicolaou testing for women without a cervix following a hysterectomy who do not have a history of high-grade precancerous lesion or cervical cancer and for women older than 65 years with adequate prior screening and who are not at high risk.<sup>1-3</sup> Few studies have investigated overuse of Papanicolaou testing among US women. We aimed to investigate overuse of Papanicolaou testing in relation to cervical cancer screening recommendations.

**Methods** | A cross-sectional study was conducted using data from the 2010 National Health Interview Survey (NHIS). The NHIS is a nationally representative survey of the civilian non-institutionalized population of the United States that uses a random, stratified, multistage cluster sampling design. Analyses of public use data are considered exempt by the institutional review board (IRB) of the National Cancer Institute; IRB approval and informed consent were obtained in the original study. In 2010, the NHIS included a Cancer Control Supplement, which is the most recently available national data set that includes detailed items on cervical cancer screening and hysterectomy status, including, for the first time, questions to assess date of self-reported hysterectomy. The Cancer