Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

From the New England Society for Vascular Surgery

2020 Rise to the challenge

Marc L. Schermerhorn, MD, *Boston, Mass*

This is not how I planned this Address to go. I had hoped for a large get-together to celebrate the annual meeting, perhaps with a breakout session of the Society for Vascular Surfing, with some Italian wine and local craft beers. I would talk about aortic aneurysms, either screening or physician-modified endografts. However, coronavirus disease 2019 (COVID-19) changed everything. It presented challenges for all of us. It brought fear and vulnerability. We were unable to care for our patients in the manner in which we had been trained, which was very frustrating. We put our practices on hold. This had affected our pay for many of us. But vascular surgeons rose to the challenge. Many of us formed line services, jumping into the fray and performing procedures on those acutely ill. Others became ICU (intensive care unit) doctors managing ventilators for COVID-19 patients. Others took care of COVID-19 patients on the floor. One of us went to New York City to help at the Jacob Javits Center. Several of our members were practicing at busy referral centers in Manhattan that were overwhelmed with COVID-19, and I suspect that they have been forever changed by the experience. We got new uniforms. We learned new terminology. Most of us had never heard of "social distancing" before, or PPE (personal protective equipment), or telehealth, or Zoom (except for those of us old enough to remember the children's television show filmed here in Boston many years ago). We have learned how to use the new technology, perhaps a bit slowly. We have all seen various troubles with the mute button and struggled with when to talk and when to listen. However, the technology is actually quite good and has helped many patients receive care. I plan to continue to use it extensively even after mass vaccination to help those patients who must travel a long distance and do not like driving and parking in Boston. The vascular surgery community should be congratulated for their management of COVID-19.

From the Department of Surgery, Beth Israel Deaconess Medical Center.

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Correspondence: Marc L. Schermerhorn, MD, Department of Surgery, Beth Israel Deaconess Medical Center, 110 Francis St, Ste 5B, Boston, MA 02215 (e-mail: mscherm@bidmc.harvard.edu).

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2020 AND RACISM

But then came another issue, one that is much harder. It can be difficult to recognize, especially when we do not look for it or if we look away. For this, no vaccine will be forthcoming. The murder of George Floyd at the hands of police was caught on film and seen around the world. It is painful to look at; however, imagine his pain, and the pain of his family, and the pain of every person of color who must worry that this could happen to them. There is Breonna Taylor, Ahmaud Arbery, Daniel Prude, and countless others that, if I took the time to name them all, I would have room for little else. This has sparked outrage and protest. The protest has been multicultural, multiracial, and multigenerational. Perhaps an opportunity is here, finally, for meaningful change.

WHY NOW, WHY HERE, WHY ME?

You might be asking why I chose to discuss this topic and why now for the New England Society for Vascular Surgery (NESVS) Presidential Address. I believe it is crucial to understand the impact on our patients, our trainees, and our society—both broadly and in our NESVS. I really did not believe it was appropriate for me to discuss anything else. I was recently asked to author a chapter for the upcoming textbook *Vascular Disease in Women,* edited by Caitlin Hicks and Linda Harris. The chapter was titled "Race and Cultural Issues in Vascular Disease." My co-author was Christy Marcaccio, and the work was based in part on previous studies completed by former research fellows Pete Soden, Tom O'Donnell, Sarah Deery, and Axel Pothof. Christy found this definition of health disparities that we liked: "A particular type of health difference that is closely linked with economic, social, or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater social or economic obstacles to health based on their racial or ethnic group, religion, socioeconomic status, gender, age, or mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion."[1] I recently read a series on structural racism and health inequities in the United States in the *Lancet*.[2] According to Bailey et al,[2] "structural racism refers to the totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, earnings, benefits, credit, median, health care, and criminal justice. These patterns and practices in turn reinforce

discriminatory beliefs, values, and distributions of resources." Health care disparities result from a complex interplay of numerous factors, many of which are challenging to study. Adil Haider's conceptual model lists five major themes, which include patient factors, provider factors, system and access issues, clinical care and quality, and postoperative care and rehabilitation, all of which contribute to disparities in surgical patient populations.[3]

HEALTH DISPARITIES IN THE UNITED STATES

Census data have shown that across the United States, black Americans constitute 13% of the population compared with 76% white and 6% Asian. However, in New England, the black population is lower at 7% and, in northern New England, decreases to less than 2%. The Hispanic population is also lower in New England at 11% compared with 19% across the United States. Data from the Centers from Disease Control and Prevention and elsewhere have predicted that the non-Hispanic white population will no longer be the majority in ~20 to 30 years, with the largest growth expected in the Hispanic population. The life expectancy in the United States is greater for women than for men (81 vs 76 years). However, it is 4 years less for black people compared with white people (75 vs 79 years) and greater for Hispanic people (82 years). Considering atherosclerotic risk factors, the epidemic of obesity is worst for black women (57%), followed by Hispanic women (47%), Hispanic and black men and white women (38%), and white men (35%) and is lowest for Asian women (12%) and men (13%).[4] Black women and men are most often affected by hypertension (41% and 39%), with the proportion for white and Hispanic men and women ranging from 26% to 28% for all.[5] Smoking rates are highest among Native American men and women at roughly 25%, followed by black and white men (23% and 18%), white and black women (16% and 15%), and Hispanic and Asian men (15% and 13%), with the lowest rates seen in Asian and Hispanic women (8% and 4%).[6]

DISPARITIES IN VASCULAR SURGERY PATIENTS

We have previously evaluated the presentation and treatment of vascular disease by race[7] (Fig 1). Analysis of the data from the Vascular Quality Initiative showed that black patients undergo vascular surgery at more advanced stages of disease compared with white patients. They are more likely to undergo carotid endarterectomy for symptomatic disease. When symptomatic, they are more likely to have stroke as the presenting symptom. They are also more likely to require abdominal aortic aneurysm (AAA) repair for a symptomatic or ruptured aneurysm. They are more likely to require lower extremity intervention for limb threat and not claudication compared with white patients. Black patients are also less likely to be treated with aspirin or a statin,

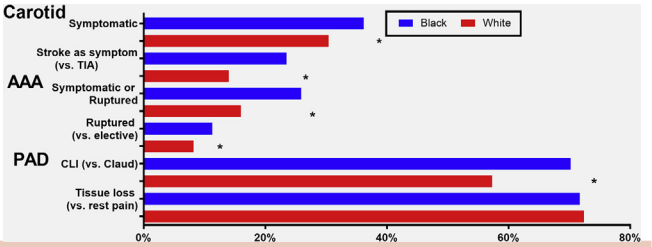

Fig 1. Black patients undergo vascular surgery at more advanced stages of disease. *AAA,* Abdominal aortic aneurysm; *CC,* Claud, claudication; *CLI,* chronic limb ischemia; *PAD,* peripheral artery disease; *TIA,* transient ischemic attack.

even at discharge, representing a missed opportunity provide an intervention. Among patients who underwent endovascular aneurysm repair (EVAR) in the National Surgical Quality Improvement Program, Hispanic and black patients were more likely to have received nonelective EVAR than were white patients (26% vs 35% vs 18%, respectively).[8] Not only are black and Hispanic patients less likely to undergo elective AAA repair, but, also, when they do undergo repair, they are more likely to receive treatment at low-volume facilities compared with white patients.[9-12] Unequal access to high-quality centers is an important contributing factor to racial disparities. Black patients are known to have increased perioperative morbidity after AAA repair compared with White patients, with longer operations, higher blood loss, longer hospital stays, more returns to the operating room, and more likely to require dialysis postoperatively. Using the Nationwide Inpatient Sample, Rowe et al[13] reported that black and Hispanic patients are far more likely to undergo amputation during ad admission for peripheral artery disease than were white patients[13] (Fig 2). Morrissey et al[14] used statewide discharge data from New York and Florida and found that compared with non-Hispanic white patients, Hispanic patients were less likely to undergo lower extremity and carotid revascularization or AAA repair but were more likely to present with symptomatic carotid disease, ruptured AAAs, and limb-threatening ischemia and were more likely to undergo amputation. John Birkmeyer's group found that among Medicare beneficiaries, black patients were less likely to undergo an attempt at revascularization before amputation compared with white patients (24% vs 32%).[15] Perez et al[16] showed that among people living in the Bronx, white patients were more likely than either Hispanic or black patients to travel to Manhattan for major surgery.

Black and Hispanic Americans have been disproportionately affected by COVID-19 with a death rate 2.8-fold greater than that for non-Hispanic whites according to the Centers for Disease Control and Prevention.[17] Martin Luther King said, "Of all the forms of inequality, injustice in health care is the most shocking and inhumane."

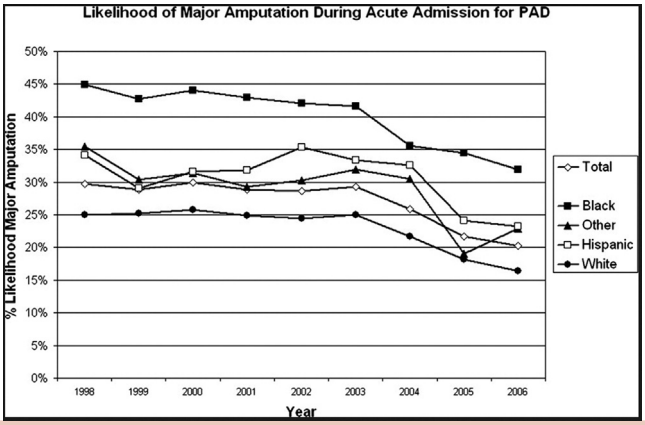

Fig 2. Black and Hispanic patients are more likely to undergo amputation during an admission for peripheral arterial disease (PAD) than are white patients.

ORIGINS OF HEALTH DISPARITIES IN THE UNITED STATES TRACE BACK TO SLAVERY

So how did we get here? This is a tough one but is crucial for real understanding. We must be honest with ourselves and acknowledge that it traces back to the origins of our country and slavery.[2,18,19] I found out last week that one of my more famous ancestors was a slave owner from a web excerpt describing how Symon Schermerhorn, an early settler of Schenectady where I grew up, was attacked during what was called the French and Indian war.[20] I had known that his family members were killed, and he was shot in the leg and rode his horse the 20 miles to Albany, successfully warning them so they could fend off the attack. However, I recently found out that he had had three slaves who were also killed—11 of the 60 people killed in the Schenectady massacre were slaves.

We often think of slavery as being a southern issue and that the northerners were all against slavery. However, 40% of the households in New York owned slaves in the 1700s.[21] Slavery was common in every New England state. The earliest slaves were primarily Native Americans until the 18th century, when they were violently forced onto reservations and were replaced with Africans. New Englanders were active participants in the slave trade and profited from it greatly. Slavery was not abolished in New York until 1827; Rhode Island banned slavery in 1843 and New Hampshire in 1865 with ratification of the 13th Amendment. Certainly, a greater number of slaves were in the south because that was where the large plantations were located; however, Northerners were guilty as well.

JIM CROW AND SEGREGATION FOLLOW SLAVERY

All freed slave families were promised 40 acres of land and a mule. However, that same year in 1865, President Andrew Johnson ordered all land under federal control returned to previous owners and only 30,000 freed slaves in the south had owned land and 4 million had not.[2,18] After slavery was abolished, conditions were still very slow to improve, with Jim Crow laws and segregation laws enacted that kept black Americans as second-class citizens. Selective imprisonment for unemployment and vagrancy led to a population of black men who could continue to provide free labor during their imprisonment or cheap labor as sharecroppers, often not earning enough to pay their rent and with extremely limited ability to buy land. Although these laws were slowly removed over many years, we still have segregation.

HOUSING DISCRIMINATION FURTHERS SEGREGATION

After World War II, the Federal Housing Administration (FHA) and Veterans Affairs provided federally subsidized housing grants that allowed primarily white people to purchase homes in the suburbs, with low-income housing built in cities.[2,18] Only 2% of the $120 billion in FHA loans from 1934 to 1962 was awarded to nonwhite families. The federal government under Franklin D. Roosevelt believed that if black families were allowed to move in to these suburbs, it would adversely affect the value of the homes they had subsidized (without evidence). In fact, the evidence was to the contrary, because black families were willing to pay more owing to their more limited housing opportunities. The FHA manual stated that the best financial "bets" were those in which safeguards such as highways separating communities could prevent the infiltration of lower class occupancy and inharmonious racial groups. The 1944 GI bill guaranteed mortgages to veterans but were designed to accommodate Jim Crow laws. Thus, banks could refuse to lend to black veterans despite the federal backing. In Mississippi, only 2 of 3000 mortgages on the GI bill went to black men, although one half of the state's veterans were black. "Red-lining" is the term that many have heard; it describes the practice of the Home-Owners Loan Corporation, established as a part of the New Deal, which created maps to assess the risk of mortgage refinancing and federal underwriting and was based in part on racial composition. Areas considered high risk or "hazardous" were colored in red; thus, the term "red-lining." Subsidized loans were not provided to the red areas. The long-term effects are evident in that 74% of these "hazardous" areas remain low to moderate income today and >60% are predominantly nonwhite.

Local politics usually pushed the low-income housing units into nonwhite neighborhoods with zoning restrictions.[2,18] City planners zoned areas adjacent to multifamily homes for commercial and industrial use with subsequent exposure to environmental hazards, further slowing the appreciation of the home values in these areas. In 1910, zoning laws were race based in that black families could not purchase homes in predominantly

white neighborhoods and vice versa. This was stricken down by the Supreme Court in 1917. However, the reason the Supreme Court gave was that this limited the ability of white homeowners to sell houses.

Real estate brokers who lived in a predominantly white suburb would often refuse to show houses in white neighborhoods to black people.[2,18] When black people did attempt to move into the suburbs, they were often met with violence and other forms of intimidation. Other real estate brokers would do something quite different, known as "block-busting," where they would tell white homeowners that a black family that moved in had lowered their property value and that they should sell to the broker immediately, telling them "don't be the last one out." They would then resell the property to another black family at a large markup.

A declining inner-city tax base and the lack of state funding led to urban decay.[2,18] Also, busing in its attempt to equalize education led to further outmigration of white people to the suburbs or to private schools, such that predominantly white inner-city schools quickly became predominately black within many cities. In addition, the suburban tax base and federal support led to business development and greater appreciation of home values in white suburbs. Rather than explicitly ban black people from neighborhoods, they were subsequently zoned for single family dwellings because white people were far more likely to be able to afford these. This prevented the building of apartment buildings and multifamily homes. At the turn of the 21st century, lenders had sold a disproportionate amount of higher interest "subprime" loans to black families, although many were qualified for better lower interest loans. At the financial crisis, black and Latino families lost 48% and 44% of their wealth, in part resulting from these practices. Another example of structural racism is the Social Security Act of 1935, which deliberately excluded agricultural workers and domestic servants, positions held largely by black men and women.

INCARCERATION + THE NEW JIM CROW

In 1972, we declared war on drugs. This led to a continuation of the disproportionate imprisonment of black men.[2,19,22] Given how common marijuana was, there could never be complete enforcement; thus, enforcement was selective. Mandatory sentencing laws were inherently racist; as an example, the punishment for possession of 1 oz of crack cocaine (affordable in poor communities) was the same as that for 100 oz of powder cocaine (preferred by the wealthy white). Possession of two "joints" has led to sentences as long as 13 years. Prisons became filled with nonviolent criminals. Labels such as "super-predators" were introduced, leading to intensified policing in black communities and harsher sentencing. At present, 1 in 3 black men will be imprisoned during their lifetime compared with 1 in 17 white men. Black men constitute 6% of the U.S. population but 40% of the U.S. incarcerated population. Even after release, they are labeled as felons and subject to legal discrimination in employment and housing. They are denied the right to vote, food stamps, and other public benefits.

Prisons also became a cash crop for private companies, as well as for some state and local police departments, being paid more for each prisoner at the expense of taxpayers.[19,22] This cash incentive to police departments created a vicious circle. The recent opioid crisis led to the incarceration of numerous white people and has forced a rethinking of incarceration vs rehabilitation. The trends of incarceration in 21 developed democracies from the 1980s through the early 2000s are shown in Fig 3. The United States is in the bottom right corner. It speaks for itself.

Sadly, this is how we arrived here, but I am only scratching the surface. If we cannot understand and acknowledge it, we are unlikely to change it.

The current disparity in accumulated wealth is striking at >100k for whites and ~7k for Hispanics and blacks.[2] Similar disparities are present in the percentage living below the poverty level at 10% for whites and ~25% for Hispanics and blacks. Unemployment is also twice as high for blacks (11%) as for whites (5%). The incarceration rates are sixfold greater for blacks than for whites and are also higher for Native Americans and Latinos than for whites. Hispanics and Native Americans have the highest rates of those uninsured (26% and 28% vs 13% for whites). Infant mortality is also twice as high in the black population as in the white population.

Two examples of employment discrimination have been highlighted by studies that showed that with fictional resumes identical other than in the name, white names such as Brad or Emily were 50% more likely to receive a call for an interview than were black names such as Jamal or Lakisha.[2] Similarly, another study found that with otherwise identical fictional applications, white applicants with a criminal record were more likely to be called for an interview than were black applicants without a criminal record.

HOW STRUCTURAL RACISM AFFECTS HEALTH

Structural racism leads to health inequities.[2,18] Most research has focused on interpersonal racism because it is easier to identify, especially when it is overt. However, microaggressions, which can be inadvertent, such as a judge asking a black defense attorney, "Can you wait outside until your attorney gets here?" also have an effect. These have been associated with primarily mental health issues such as depression, anxiety, loss of self-esteem and life satisfaction but also with sleep disturbances that can affect physical health.

Residential segregation affects access to transportation, education, employment opportunities, home value

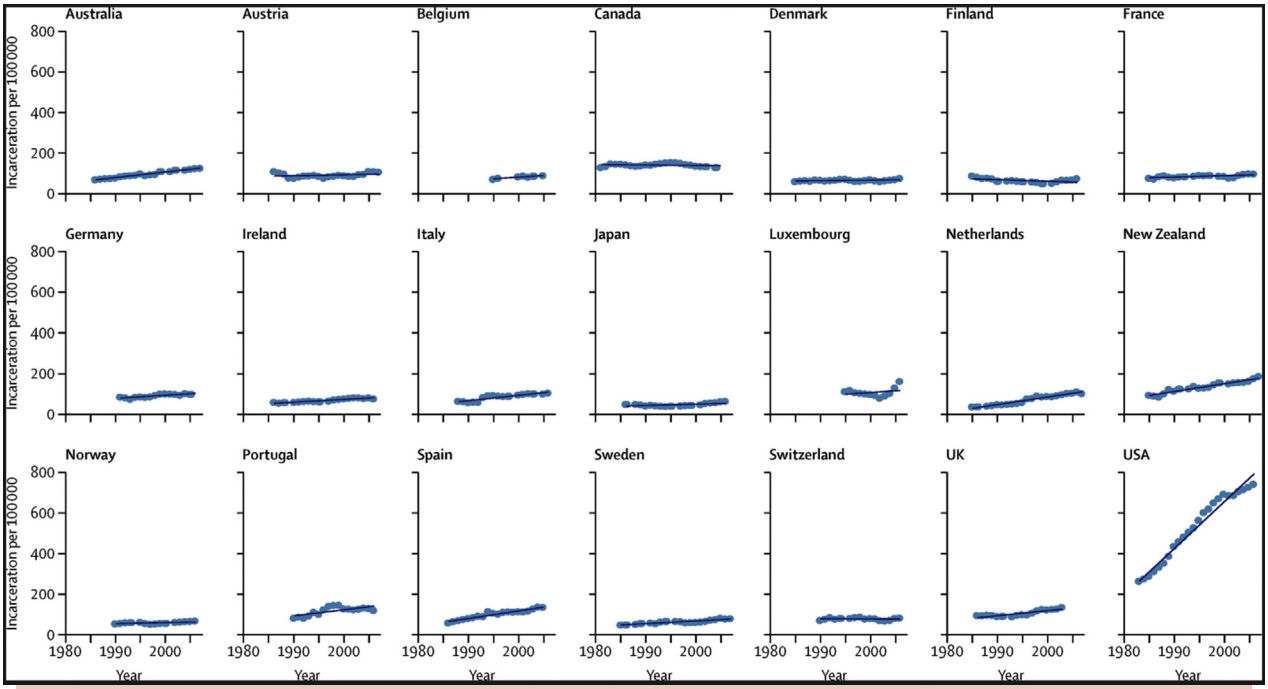

Fig 3. Incarceration rates in 21 developed countries from the 1980s to 2000s.

appreciation, and health care.[2,18] It leads to adverse birth outcomes; exposure to pollutants in air, water, and paint; decreased longevity; increased chronic disease; and homicide and other crime. It also shapes health care access, usage, and quality, which occurs at the level of the neighborhood, health care system, and individual. It is often difficult to attract primary care providers and specialists to poor black and brown communities. The distribution of resources is unequal, with lower quality facilities, fewer clinicians, and clinicians with lower clinical and educational credentials.

Incarceration has adverse health effects.[19,22] Those imprisoned are more likely to develop mental health disorders, infectious diseases, hypertension, diabetes mellitus, asthma, and substance use disorders. After release, they have decreased access to primary care providers, medications, insurance, and safety net services and experience increased mortality and chronic diseases. While in prison, the racial disparities are actually muted. Prison adversely affects all those imprisoned, it is just that black men (and black women) are imprisoned much more often than are white men (and white women). The impact on families is more difficult to study. However, research has shown that the loss of income from the inmate, combined with the high costs of visitation and, even, telephone calls at 25 cents per minute, have an effect. This is combined with stress and stigma and loss of social support. Children have been found to have higher mortality, higher levels of inflammatory markers, and a greater incidence of anxiety and depression, obesity, asthma, and substance abuse. Also, the partners of those imprisoned have been found to have higher rates of mental health disorders and cardiovascular disease. A measurable effect even occurs on states and nations, because those with higher rates of incarceration have higher mortality rates. Studies have shown that if U.S. incarceration rates had remained at the level of the mid-1980s, U.S. life expectancy would have increased 50% more and infant mortality would have decreased 40% more from 1983 to 2005. Compounding the issue further, essentially all U.S. public health surveys have excluded inmates, leading to substantial underestimates of disease prevalence and racial disparities. Finally, inequality in income and education leads to a greater likelihood of no insurance or Medicaid insurance and decreased health literacy.[2]

WHAT CAN WE DO?

So, what can we do about it? Actually, quite a bit. Change is needed on a macro level. We need to stop the prolonged incarceration for nonviolent crimes, improve the rehabilitation programs, and decriminalize or legalize marijuana. We must fix the problems with housing inequality and neighborhood segregation. Multiple examples exist of neighborhood renovation projects in cities such as Seattle, Atlanta, Albuquerque, Austin, Grand Rapids, Louisville, and Philadelphia.[2] Federal programs began with the Civil Rights movement in the 1960s but should be updated to overcome loopholes. New federal initiatives were introduced 2010. The mayor of Austin Texas noted "Government helped create a lot of the inequities, it institutionalized them. It's important for the government, the city government, to address racial

inequity, not just because of the conditions, but also because we helped create it." He is right.

We need other fair housing initiatives to overcome the race and income residential segregation by reducing exclusionary zoning uniformly across all communities. Massachusetts has had a program in place, as have a number of other states. In Massachusetts, if any town has <10% of homes for sale or rent at a price that is less than what is considered affordable—which is a household earning <80% of the median income, a developer can build more densely than what local zoning laws allow, as long as 25% of the units being developed will have long-term affordability restrictions. I can speak about this in my hometown where a development was proposed for a large mixed-income housing area. Many of us, myself included, worried about the effects on our commuting times because the development would be built on the main road I use to commute. Others were concerned about the effects of large numbers of additional children on the school system. Some might have had concerns about their property values, and, perhaps, some had more sinister concerns. I now have a better understanding, and I do not mind a couple minutes longer commuting time—although this has not happened—at least not at the hours I travel. I have always thought our town would benefit from more diversity. I now understand how important this truly is. I hope others will keep this in mind as new developments come to their town as well. This is a good thing. The Massachusetts program stood up to a referendum attempting to strike it down.

As my son Michael likes to point out, the importance of voting in local elections cannot be overstated. Although it is important to have drug and incarceration policies changed on a national and state level, the locally elected district attorney or prosecutor determines what types of cases and which people will be prosecuted. State representatives decide the voter registration and identification laws, which, to this day, are used to suppress voting. Local elections will affect zoning, affordable housing, law enforcement, educational curricula, school funding, marijuana laws, and a host of other issues. Your individual vote is far more likely to have an impact in local elections than in national elections. Do the research to find out where those running for local office stand on these important issues.

We need to look more like our patients. We need more minority physicians. A study from Stanford randomized black patients to see either black or white doctors.[23] Those with black physicians were more likely to comply with preventative measures such as screening studies and antihypertensive and antiplatelet medications. They were more likely to agree to invasive procedures when recommended. They estimated that if all the black patients saw black doctors, this would reduce the gap in cardiovascular mortality by 19% and the gap in life expectancy by 8%.

DIVERSITY IN VASCULAR SURGERY

So how is our diversity as physicians? Data from the American Association of Medical Colleges show that it is improving but we still see underrepresentation of black and Hispanic people in our medical school graduates, with black and Hispanic persons constituting just 6% and 5% of medical school graduates in 2019.[24] Black applicants are less likely to be accepted to medical school than are other groups (34% for blacks vs 42% for Asian and Hispanic and 44% for whites). Women have caught up and constitute 51% of medical school graduates. However, among those older such as medical school faculty, diversity is still lacking, with only 39% women and 4% black. Among vascular trainees in 2017, only 31% were women. Information about race is not currently available; however, the Association of Program Directors in Vascular Surgery is working on finding that information. Some specialties in medicine are dominated by women such as obstetrics and gynecology (83%), pediatrics (72%), and dermatology (61%). In contrast, others are male dominated, with orthopedics (85%) the highest, and neurosurgery (83%), interventional radiology (81%), and cardiothoracic surgery (78%) close behind. The American Medical Association did not provide data for vascular surgery. However, Kim Hodgson recently reported the numbers from the SVS at the virtual Vascular Annual Meeting. Overall, we have only 15% women, right there with orthopedics. However, when stratified by age, progress is being made, because women constitute 38% of those aged <40 years. Ethnic diversity is also lacking, with 73% white, 15% Asian, 6% Hispanic, and 2% black. The SVS Executive Board created an Equity, Diversity, and Inclusion Task Force, co-chaired by John Eidt and our former fellow Bernadette Aulivola, with two NESVS members, Julie Lahiri and Linda Wang. The task force is charged with studying these issues more broadly and developing recommendations for improvement.

What about our NESVS? We only have data for sex, but we have a similar breakdown, with only 15% women overall, which increases to 34% for those aged <45 years, and 33% of our Executive Council are women.

A CALL TO ACTION

I call on the NESVS to also set up a task force to study these issues, to get more detailed data, and to help us strategize to find ways to recruit more minorities and women into our specialty, to provide mentorship and to improve teamwork and the care of our patients. Each of us can contribute to this effort. We should reach out to students before they have a career path. We should identify and mentor those from underrepresented groups at all levels. I am not suggesting the promotion of someone who does not have the tools to succeed but, rather, to help them develop the skills to succeed and then advocate for them. We should

embrace diversity at all levels, in our practices, our hospitals, and our patients. We can all learn more about our patients, try to understand their culture, and learn to communicate better. We should be asking questions to ensure our message is coming across. We should ask our patients how they prefer to learn about vascular disease. We need to educate ourselves and adapt ourselves. Learn a new language. You are never too old. Take a class in how to identify bias in yourself and others and how to respond to both. I recently did and learned quite a bit.

There are many ways to contribute. Be creative. My children started a laptop drive to help poor immigrant families who came from Haiti, Africa, and Latin America and are currently living in Mattapan, Roxbury, and Dorchester, who have been disproportionately affected by racism and COVID-19. You can start a similar program in your area or contribute to theirs. Reach out to local nonprofit organizations or community organizers to determine where the greatest needs are and how you can contribute.

Why me? Why now? I asked this at the beginning, and I am the first to admit that I am probably not the best person to give this Address. I have benefitted from white male privilege. I mentioned my ancestors. I am probably not the best person at communicating with black and Latino patients. However, if only black and Latino people speak up, fewer will hear. We need all voices together.

I quote Martin Luther King again, who said: "the ultimate tragedy is not the oppression and cruelty by the bad people but the silence over that by the good people." Do not be afraid to speak up when you see or hear something that is wrong. The person doing it might not even recognize or intend it. Be an advocate for change. As Dr King said, "the time is always right to do what is right." That time is now. We have another challenge ahead of us, and I truly believe we are up to the task.

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