surgery; however, the thoracic surgeon's input is important in the shared decision-making process. As a collective of thoracic surgeons, we have a moral obligation to offer the best care to all of our patients without exception. The study by Savitch and colleagues³ is important because it provides us with insight into an area that we need to investigate further and for which we need to be better.

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Commentary: A disparity anywhere is a disparity everywhere

Philip A. Linden, MD

The article by Savitch and colleagues¹ uses data from the National Cancer Database to examine differences in lung resection rates for clinical stage I cancers for Black compared with White patients between 2006 and 2016. Differences in the utilization of surgery is analyzed by geographic region, center volume quartiles, and academic classification of facility. Although the national difference in the percent of White patients versus Black patients offered surgery over time decreased from 9.0% in 2006 (56.2% for White patients vs 47.2% for Black patients) to 4.0% in 2016 (56.2% for White patients vs 52.1% for Black patients), the New England, West North Central,

Philip A. Linden, MD

CENTRAL MESSAGE

Disparities in delivery of surgical care to patients with early-stage lung cancer remain and must be addressed at every stage of care.

and Pacific regions saw an increase, as did the facilities in the lowest quartile of volume.

A major weakness of the article is that the authors fail to include a comprehensive table detailing the statistical significance in the changes of surgical care offered over time across all regions and networks examined. Second, although significant differences in comorbidity scores between Black and White patients are noted in some of the regions, the cause of surgery delivery disparities is not addressed and there are no suggestions as to how to remedy these disparities.

Possible explanations for the disparities include differences in insurance coverage, comorbidities, socioeconomic factors, distrust in health care, and bias. A multivariable logistic regression analysis incorporating age, sex,

From the Division of Thoracic and Esophageal Surgery, Department of Surgery, University Hospitals Cleveland Medical Center and Case Western Reserve School of Medicine, Cleveland, Ohio.

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Address for reprints: Philip A. Linden, MD, Division of Thoracic and Esophageal Surgery, Department of Surgery, University Hospitals Cleveland Medical Center, Case Western Reserve School of Medicine, 11100 Euclid Ave, Cleveland, OH 44106-5011 (E-mail: Philip.linden@uhhospitals.org).

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comorbidities, and insurance status suggests that, after accounting for these variables, no disparity favoring White patients exists. The authors do not comment on this analysis, but the analysis suggests that factors other than bias may account for much of the difference.

The most important takeaway message is that although the overall difference in surgical care offered has decreased over time, a disparity still exists, and, in certain regions, has worsened. Although we cannot discern the determinants of this disparity, recognizing that a disparity anywhere must be

addressed as a disparity everywhere is the first step in addressing this problem. We must all remain vigilant regarding health care disparities, and the issue must be addressed in every region, every state, every county, every hospital, every clinic, and every operating room.

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