Race and Ethnicity in Orthopedics
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Little was published on racial disparities in the field of musculoskeletal activities when I wanted to join the residency program at Howard University Hospital in 1983. I may want to explore the topic and address this issue as objectively as possible in throwing my glance over the years of training in my adopted country.

In leaving Haiti at the end of Dec 1979, I was already a capable specialist in the field of orthopedics with three years of passionate training under my belt, during which I was the Chief-Resident in the service of Orthopedic and Traumatology at the State Univerity Hospital in Port-au-Prince. During my last year, I was also a fellow-Attending physician at the OFATMA Hospital. This second hospital was the place dedicated to provide medical and trauma care to the industrial victims. I loved this unique situation in which, as a young Orthopedic fellow, eager to learn the rudiments of the polytraumatized patient in the industrial world, I was performing in the best of my ability. I was appointed to the position by the Minister of Health, (Willie Verrier MD) under the explicit recommendations of the chief of Orthopedics and Trauma (Anthenor Miot MD) at the University Hospital in Port-au- Prince, where I just finished my third year of residency in the program. I left Haiti at the end of December 1979 to join my wife and my 2 children already living in Silver Spring MD.

I was lucky enough to have soon, the opportunity, to start working in the Operating room at Alexandria Hospital, in Virginia, just a week after my arrival in the United States. I was not ready yet to start in a residency program because after passing my ECFMG medical examination in Haiti, I needed to pass an efficient English test to complete my certificate and with it, obtain

the right to start in any residency program. This English test was given only twice a year. I was fortunate enough to be one of the rare physicians on campus to pass the test in Haiti and reach the United States in quest of better knowledge. In Alexandria Hospital, Virginia, I was assigned to a group of Orthopedica, obstetrical and plastic sugeons. It was a way for me to gain more experience and get used to the routine of the operating rooms in the United States. I was received with open arms because they were looking for someone with my skills and experience to help in their challenging cases. I jumped blindly on the opportunity and never regretted it. This work allowed me from the start to assume financial responsibility for my little family.

I sympathized so well with the orthopedic team and met two exceptional surgeons (Charles and Paul ENG) two famous brothers, working also at an other hospital "National Orthopedics" in Arlington, VA. They become so happy to use my help while I was learning their routine, that soon, they offered me a spot to enter in the residency program in Orthopedics that they were running at an other institution (National Orthopedic Hospital). Unfortunately a new academic law, recently voted against any such orthopedic program unaffiliated to a University Hospital. Unfortunately, any training I would have been able to acquiere with them, would have not been recognized anymore. I had to back down. I lost my enthousiasm, even if I were already given a firm date to start on the 1st of July 1980. I continued to enjoy my assigned duty as a physician in the operating room at the Alexandria Hospital until December 1980, when I passed succesfully the English portion of the ECFMG. Indeed, I gained the right to apply in a General Surgery residency program.

I was happily accepted at the Prince Georges's General Hospital, Cheverly MD, a shoc Trauma Center, in the General Surgery residency program of Dr Saddler. Unfortunately, theywere not able to offer me a positinon in an Orthopedic Residency training program and despite of being offered an other year in the General Surgery program, I took the opportunity to join the General Surgery program of Dr Lassalle Lefalle at Howard University Hospital, in Washington DC, in June 1981. Neverless, I was eagger to start and tought that my path was already traced and that soon, I would be accepted in Orthopedic Surgery. In fact, that was the most rewarding years under the pressure of being a young surgical resident coming from Haiti and where everything was especially reminding you that you were stigmated with the "4 H" group. Our blood was refused even if one had a rare type, pressure was placed on our shoulders in order to jump-up into the pyramidal system, in order for you to perform well during the in-training service's examinations.

Residents and interns were looking at you differenly, like by curiosity, because of our french accent was a striking trademark.They were hiding knowledge from us to render the transition more difficult. I felt their fear of seeing us overtaking their spots in the hierardhy. We learned soon that studebts and residents share between them special notes relevant to the questionning of the Professors while making early morning rounds: Questions and Answers often looked for by the Chief of the department while performing rounds on patients were distributed among them. Unfortunately, they were refusing to share such knowledge with us. This was the first time in my entire life that I felt so much discrimination althrough I had alreeady competed in a previous surgical program at Prince George's Hospital in Cheverly MD, prior to Howard.

Slowly, we made our marks and adjustments. We imposed our acceptance especially when our competence overshadowed the critics. We were better skilled and were performing well in practice. My Chief in General Surgery (Lassalle Leffall MD) did not want me to go to the Orthopedic program and he believed that I would be better suited in the general surgical program. He enjoyed working with me and soon I found out that I was priviledged to start some of his cases while he was still closing the previous one in an other room. It was a charm to work with him and he tought us humility and respect. He tried to show us how to calm the aggressivity that so many islanders have, coming over in this country.

Factors like age, sex and ethnicity and even social economic conditions did not appear to play any specific role in the relation between residents because it looks at the end that we belong to the same boat at the difference that the one who went to Howard Medical School have the tendency of thinking that they were better prepared. We were all eager to participate in researches and have our names scripted on a specific paper to have them published in a respected orthopedic journal. We were told also that it was essential to advance in the hierarchy.

I decided to get interested in a topic that was important for me because I had the opportunity to get involved with patients with Sickle cell Disease in my native country. I had numerous children treated with Osteomyelitis and it was often difficult to know how to handle them medically and surgically. The problem is that I was still a resident in the General Surgery Department. Years have passed and in becoming a senior resident in the General Surgery program, it becomes my privilege to rotate into the orthopedic service and the subspeciality services and while many of the residents in General Surgery did not appreciate that rotation, I was always volunteer to take their spot and make a change in

scheduled rotations. I performed well and continue the review of patients with sickle cell disease developing bone infections. Soon, I was chosen as a resident in Orthopedics and started I the program on July 1983.

Once I become accepted in the orthopedic program, my research was already far advanced and because Howard University Hospital was a referral center for so many African countries, I was able to choose a diversity of cases to write a strong paper which was presented to the Journal of Bone and Joint Surgery for publication. I reviewed all medical records at Howard University Hospital with a diagnosis of infection and sickle cell, I consulted with Dr Castro at the Sickle Cell Center Laboratory of Howard University and diagnosis like Dactylitis, Joint infections, and Bone infections (Osteomylitis) were looked for to determine the specific pathogens and the appropriate management. My chief of Department and other who participated in the researches added their names to mine. I had an advance on most of the other residents in submitting such paper.

You will think that such accomplishment would give me a better acceptation among the other residents and attending. Never less, I overheard one stating to others that I was able to get interviews at the end of my residency, because I had an accent. Although, we were four Chief-residents leaving the program at Howard University Hospital, in June 1987, and I was the only resident who was offered many interviews for a future academic position. I went to Wisconsin, Illinois, Tennessee etc… but I finally accepted a position with Meharry Medical School of Medicine to become the Chief of Orthopedic at the Alvin C. York Veteran Administration Hospital in Murfreesboro TN, while I was also an Assistant Professor at The Meharry Medical School and Center. I become also a consultant at the Air Naval Military Base in Millington, TN.

At Howard University Hospital, most of the residents were Afro-American from the United States, the Caribbeans, some African or South American Countries like Nigeria, Mexico, Argentina…, etc. Rare residents were from Jewish descent and were medical students at Howard University School of Medicine, prior to enter a residency program. Others were from India, Egypt and the Philippines etc… It was a melting pot where all of us were in spite of all, happy to learn and participate in the American dream. Recently, an Editorial published in the JBJS stated that the AMA itself make little allusion to Race and Ethnicity until an unproportionate amount of Males vs Females residents were discovered by the media. Diversity was never reflected in Orthopedic Surgery. Earlier, it was a privilege given to many Caucasian sons of famous Orthopedists to follow the steps of their parents.

Nowadays, many institutions have made an effort to accept a quantitative number of young male and female physicians, representative of the racial and ethnic minorities in order to introduce more diversity among orthopedic residents. In the early eighties, I had to wait more than 3 years prior to be admitted in an orthopedic program. Many were unlucky and needed to change their choice of residency and opt for another program. At Howard University Hospital, we had 16 residents, in a pyramidal orthopedic program, 4 in each year but only one female resident, and I can imagine how she managed the constant tension of being a woman in a strictly male program.

Data were reviewed and an article, published in the Journal of American Medical Association (JAMA) reported on African American participation from 1968 to 2008: especially, a young lady of the name of Ruth Jackson MD was the first to reach the American Academy of Orthopedic Surgery… Hispanics from 1990 to 2008, Asians from 1995 to 2008 and from American Indians, Alaskan and Hawaiians or Pacific Islanders from 2001 to 2008. The late 1990's and earlier 2000's has shown an increase in the participation of Asians, Hispanics and Afro-American in Orthopedics although the specialty remains the least diverse in all training programs.

Many in the African American Community believe that even if in 1932, the young lady of the name of Ruth Jackson was the first to break the barrier and reach the American Academy of Orthopedic Surgery, the gender inequality has not stopped. We have seen a steady improvement but some groups remain privileged but we always hope to be able to see even more progress. Recent data has shown that there are advantages in diversity not only in our field of medicine while dealing with patient care but also in different business societies. Knowing the background and the socio-economic habits of the population we are providing care; it is believed that a better message is now being delivered. *It remains* so important to promote gender and cultural diversity, especially in the field of orthopedics and now, the visibility of the opposite sex has tremendously improved the relation between Physicians and Patients.

People believe that race, language, culture or even gender facilitate social roles and bring experience. Nowadays, the AMA reports that 50% of medical school graduates are women but only 14% were represented in the field of Orthopedics. More ten years ago, we were

able to find around 14 white young medicals applying to a residency program against only around 4 of African Americans or Hispanics, but the ratio was even worse for women which represented 1 female for every 6 male applicants. Think a little how we fought in the 80's, as an islander coming from Haiti, carrying the stigma of being part of the 4 H group with HIV/AIDSHIV/AIDS.

A Mexican medical team visiting us at the State University of Haiti during the mid-1970's to promote diversity.

Diversity was recognized and appreciated also in the workplace, when it was found out that it broadens the consumer market and stimulate growth to a point that companies started to hire female CEO's (Kraft Foods and DuPont) with a wide range of skills, to widen their perspectives and their backgrounds. It was demonstrated in the medical field that African American and Hispanic patients were almost 50% less likely to undergo a Total Knee Replacement than white patients. The same was seen in African American in need of a Kidney Transplant. Definitively, more, patients were satisfied of their treatment when they were able to communicate with a provider of their own background and culture and discuss their problems. Diversity in the medical team brings benefits and institutional culture but also contribute to the advancement of the medical profession.

At Howard University Hospital, and through the Orthopedic Residency program, we knew well, as residents about the efforts of Dr J Robert Gladden, who became the first African American, board-certified in the field of Orthopedics. He taught us at the Hospital and founded later in 1998, the "J Robert Gladden Orthopedic Society" with the distinct mission to increase diversity in Orthopedics. The Gladden Society counts more than 500 active or retired members which center their efforts on eliminating disparity. They encourage research and education as well; They promote an orthopedic society where healthcare disparities in patients with musculoskeletal disorders will cease to exist.

Other societies have joined efforts especially "The Women Orthopedist Global Outreach" founded in 2006 by 5 female orthopedists with the mission to provide free orthopedic care to the underserved communities worldwide. They may be focusing on women but may also provide care to anyone in need. Multiple mission trips in Nepal, Guatemala, Cuba, Tanzania, Congo can be placed on their credit. Local orthopedist can be also trained to improve health in their communities. Young volunteers can participate through mentorship.

Diversity has bought changes in the nation where we refuse to see less than 2% of African American and Hispanics, or .4% Native American while more than 80% of White medical students are given the opportunity to train in the field of Orthopedists. We see also the way, women are entering the medical field to compete and bring diversity. They become as qualified to run their Orthopedic Department. More than 20 of them, recently, matched in orthopedic spots to perform as Orthopedic residents. It is time for a change in the medical world in which we grew up as Orthopedists. Definitively, one should hesitate to join any program which does not offer diversity in training male and female African Americans, Hispanics or American Indians. This is at least what legacy has allowed diversity to bring in healthcare through the United States. With reason, the Accreditation Council for Graduate Medical Education (ACGME) has recently added "Diversity" to their requirements.

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