J. Robert Gladden Orthopaedic Society

INAUGURAL MEETING

Lausanne Palace & Spa

Lausanne, Switzerland

July 6 – 10, 2006

Perspectives in Orthopaedic Professionalism, Diversity and Health Disparities

Charles L. Nelson, MD, Augustus A. White, III, MD, PhD

Meeting Program Co-Chairs
The J. Robert Gladden Orthopaedic Society (JRGOS) is a pluralist multicultural organization designed to meet the needs of minority orthopaedic surgeons, and to advance the ideals of excellent musculoskeletal care for all patients with particular attention to underserved groups. It provides comprehensive educational experiences designed to create awareness, sensitivity and knowledge of the unique needs of minority populations requiring musculoskeletal care. The JRGOS provides education to all orthopaedic surgeons, patients, the public and health policy decision-makers. The JRGOS accomplishes this mission by promoting pluralist membership and providing value-added services for all orthopaedic surgeons interested in addressing the special needs of underserved patients.

Our mission is to increase diversity in the orthopaedic profession, improve musculoskeletal patient care by improving culturally competent care and eliminate musculoskeletal health care disparities in underserved groups.

Welcome to Switzerland and to the beautiful Lausanne Palace Hotel & Spa. We are delighted that you have chosen to participate in the inaugural meeting of the J. Robert Gladden Orthopaedic Society and hope that your involvement will be academically fulfilling and culturally enriching.

Arrangements have been made for what we hope will be four special days in Lausanne. The meeting program consists of a large number of renowned orthopaedic and diversity experts from distinguished institutions who will address the need for culturally competent care and ways to eliminate health disparities in orthopaedics. Emphasis will be on the importance of building a strong foundation that enables the medical community to better care for our culturally diverse communities—now and in the future. The program includes ample opportunity for discussion to further explore strategies for solutions.

In addition to this dynamic program, we invite you to enjoy the breathtaking views of Lake Geneva and the Alps in this most picturesque city in Switzerland. Just steps from the hotel you can sample culinary delights at neighboring gourmet restaurants, discover local artisans and their quality Swiss made products, visit nearby Montreux for some of the best music from around the world and experience festive Brazilian jazz on our Saturday afternoon Jazz Boat excursion. As you can see, there is something for everyone.

We hope that you enjoy your stay and have a rewarding experience in this magnificent multicultural setting.

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Charles L. Nelson, MD and Augustus A. White, III, MD, PhD
Program Chairs
J. Robert Gladden Orthopaedic Society

INAUGURAL MEETING

The J. Robert Gladden Orthopaedic Society would like to thank the following for their outstanding contributions in making the 2006 Inaugural Meeting a success.

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BREAKFAST, BREAKS & EDUCATIONAL PROGRAM

Breakfast is available every morning between 7:00 am - 8:00 am in Salle Richemont

General Session commences each day at 8:00 am in Salon J. P. Delamuraz and Salon Olympique

Breaks are scheduled each day between 10:00 - 10:30 am in Salle Richemont
Special Event
FRIDAY, JULY 7, 2006
9:00 PM

For 40 years of vision and leadership and contributions to multiculturalism
at the Casino Barrière in Montreux

Special concert immediately following featuring Chick Corea Mozart’s Project
organized in cooperation with the Montreux-Vevey Classic Festival
60th anniversary

Claude Nobs & The Montreux Jazz Festival

Claude Nobs, who was already at the time a jazz enthusiast and an eternal dreamer, used to work for the Tourism Office of Montreux, when he founded the Montreux Jazz Festival in 1967. During its first edition, the Festival lasted 3 days. In 1973, Claude Nobs was appointed director of the WEA (Warner Elektra Atlantic) in Switzerland. In 1977, the Festival reached its longest length with 23 days and is definitively characterized by its eclectic posters.

Today, the Festival presents 16 days of international music to hundreds of thousands of spectators coming from the four corners of the world, to which we can add television viewers and radio listeners. Quincy Jones has been, from the 25th edition until 1993, co-producer of the Festival with Claude Nobs.

Far from resting on a more than satisfying accomplishment, the Montreux Jazz Festival moves with the times, follows and sometimes even precedes its evolution, by satisfying, surprising and continually renewing the expectations of an audience that expects the best in music. This is how Claude Nobs rapidly opened the Festival’s doors to other rhythms such as rock, blues, rap, Brazilian music, electronic music, and even to symphonic music and French songs.

The presence of the most renowned names in Montreux can be explained not only by the warm atmosphere that one can find, Claude Nobs’ and his team’s unique welcoming, but also by the non-stop development of this event.

Montreux’s success is a result of Claude Nobs’ intuition, open-mindedness and craze for music. Thirty-nine years later, his enthusiasm remains.

CONTINUING EDUCATION CREDIT
This activity has been planned and implemented in accordance with the Essential Areas and policies of the Accreditation Council for Continuing Medical Education through the joint sponsorship of the American Academy of Orthopaedic Surgeons and the J. Robert Gladden Orthopaedic Society. The American Academy of Orthopaedic Surgeons is accredited by the ACCME to provide continuing medical education for physicians.

The American Academy of Orthopaedic Surgeons designates this educational activity for up to 16.5 credit hours in Category 1 of the Physician’s Recognition Award. Each physician should claim only those credits that he/she actually spent in the educational activity.
Perspectives on Orthopaedic Professionalism, Diversity and Health Disparities

July 6-10, 2006
Palace Hotel and Spa, Lausanne, Switzerland

Augustus A. White, III, MD, PhD
Charles L. Nelson, MD

Panelist 3 – Sheryl L. Conley

11:50-12:00 pm
Women and Minorities in Orthopaedic Residency Programs
Panelist 4 – Kimberly J. Templeton, MD

12:00-12:15 pm
Health Disparities in Women
Panelist 5 – Joan Y. Reede, MD, MPH, MS

12:45 pm
ADJOURN

SATURDAY, JULY 8, 2006

7:00-8:00 am
BREAKFAST – Salle Richemont

8:00 am
GENERAL SESSION – Salon J.P. Delamuraz and Salon Olympique

THE IMPORTANT CAUSES OF HEALTH DISPARITIES
MODERATOR: Charles H. Epps, MD

8:00-8:30 am
Opinions, Views and Evidence on Causes of Health Disparities
Keynote Speaker – John Ruffin, PhD

8:30-8:50 am
Understanding and Addressing Racial/Ethnic Disparity in Joint Replacement Utilization: Results from VA-based Research
Panelist 1 – Diane L. Rowley, MD, MPH

8:50-9:10 am
Ideas, Perspectives and Evidence on Causes of Health Disparities
Panelist 2 – James N. Weinstein, DO, MS

9:10-9:30 am
Views on How to Improve Diversity in Orthopaedic Residency Programs
Panelist 3 – Mark C. Gebhardt, MD

9:30-10:00 am
DISCUSSION & QUESTIONS

10:00 am
BREAK – Salle Richemont

SOME WAYS TO ELIMINATE HEALTH DISPARITIES
MODERATOR: Mark C. Gebhardt, MD

10:30-11:00 am
Opinions, Views and Evidence On Ways to Eliminate Health Disparities
Keynote Speaker – John Ruffin, PhD

11:00-11:20 am
How to Reduce Health Disparities in Underserved Populations
Panelist 1 – Louis W. Sullivan, MD

11:20-11:40 am
Perspectives on Solutions to Decrease Health Disparities
Panelist 2 – Richard A. Williams, MD

11:40-12:00 pm
Cobb Institute Strategies to Eliminate Disparities
Panelist 3 – Randall C. Morgan, Jr, MD, MBA

12:00-12:30 pm
DISCUSSION & QUESTIONS

12:30 pm
ADJOURN
SUNDAY, JULY 9, 2006

7:00 – 8:00 am BREAKFAST – Salle Richemont
8:00 am GENERAL SESSION – Salon J.P. Delamuraz and Salon Olympique

HOW WE CAN IMPROVE HEALTH PROVIDER DIVERSITY
MODERATOR: E. Anthony Rankin, MD
8:00- 8:30 am Ways to Improve Health Provider Diversity
Keynote Speaker – Louis W. Sullivan, MD
8:30- 8:50 am Opinions and Recommendations on how to Increase Diversity in Orthopaedic Faculties and Residency Programs
Panelist 1 – James N. Weinstein, DO, MS
8:50- 9:10 am The Challenges of Orthopaedic Department Chairs in Achieving Diversity
Panelist 2 – Ronald W. Lindsey, MD
9:10- 9:30 am Successful Increase in Orthopaedic Diversity: A Case Study
Panelist 3 – Claudia L. Thomas, MD
9:30-10:00 am DISCUSSION & QUESTIONS
10:00 am BREAK – Salle Richemont
10:30 am MODERATOR: James M. Weinstein, DO, MS
10:30-10:55 am Why Winners Win: “Are Juries Affected by Ethnicity and Gender?”
Special Lecture – Linda S. Crawford, JD
10:55-11:00 am OPEN DISCUSSION
11:00 am ACTIVITIES IN CULTURALLY COMPETENT CARE EDUCATION (CCCE)
MODERATOR: James A. Hill, MD
11:00-11:30 am A Law School Dean’s Perspectives on CCCE
Keynote Speaker – Christopher F. Edley, Jr., JD, MPP
11:30-12:00 pm Current Activities in Orthopaedic CCCE
Panelist 1 – Ramon L. Jimenez, MD
12:00-12:30 pm Overview and Perspectives in CCCE
Panelist 2 – Augustus A. White, III, MD, PhD
12:30- 1:00 pm DISCUSSION & QUESTIONS
1:00 pm ADJOURN

MONDAY, JULY 10, 2006

7:00- 8:00 am BREAKFAST – Salle Richemont
8:00 am GENERAL SESSION – Salon J.P. Delamuraz and Salon Olympique

HEALTH DISPARITIES AND PUBLIC POLICY: OPPORTUNITIES AND RESPONSIBILITIES
MODERATOR: Professor Charles J. Ogletree, Jr.
8:00- 8:30 am Opportunities for Public Policy Impact on Health Disparities
Keynote Speaker – Christopher F. Edley, Jr., JD, MPP
8:30- 8:50 am Perspectives on the Origin of the New Jersey Law S-144
Panelist 1 – Eric Muñoz, MD
8:50- 9:10 am Race in VA Health Services Research: A Social Construct
Panelist 2 – Said A. Ibrahim, MD, MPH
9:10- 9:30 am The Importance of Genetic and Sociopolitical Perspectives on Health Policy
Panelist 3 – Perry W. Payne, Jr., MD, JD, MPP
9:30-10:00 am DISCUSSION & QUESTIONS
10:00 am BREAK – Salle Richemont
10:30-11:00 am Concepts and Perspectives on the New Genetic Race Realities
Keynote Speaker – Professor Charles J. Ogletree, Jr.
10:30-11:00 am Perspectives on the Definitions of Race and the Impact on Health Studies
Panelist 1 – Said A. Ibrahim, MD, MPH
11:00-11:20 am Early and Current Insights About Race and Medicine
Panelist 2 – Richard A. Williams, MD
11:20-11:40 am The Role of Genetics and Sociopolitical Definitions of Race in Clinical Trials
Panelist 3 – Perry W. Payne, Jr., MD, JD, MPP
11:40-12:00 pm DISCUSSION & QUESTIONS
12:00-12:30 pm ADJOURN
12:30-12:40 pm CLOSING REMARKS
Charles L. Nelson, MD
Perspectives on Musculoskeletal Health Disparities

JAMES N. WEINSTEIN, DO, MS  
FRIDAY, JULY 7 • 8:00 - 8:30 AM

Abstract not available at time of printing.

Some Hispanic Perspectives on Musculoskeletal Health Disparities

ERIC MUÑOZ, MD  
FRIDAY, JULY 7 • 8:30 - 8:45 AM

Health disparities exist across racial and economic lines. Blacks, Hispanics, Pacific Islanders, and American Indians have been shown to have great disparities across many health outcomes, and operative procedures.

Blacks have been shown to have disparities for musculoskeletal diseases, compared to other Americans. Rates of musculoskeletal disorders are higher, and rates of operative procedures for these disorders are lower when compared to other Americans.

The reason for these health disparities will be explored including income, health coverage, cultural sensitivity and the numbers of health providers, and ethnicity to explain these differences.

Perspectives on Orthopaedic Oncology

MARK C. GEBHARDT, MD  
FRIDAY, JULY 7 • 8:45 - 9:00 AM

There is very little data on the effect of diversity on health disparities with respect to musculoskeletal neoplasms. It is well recognized that certain bone tumors are rare in African Americans, such as Ewing sarcoma and chordoma, which are seen almost exclusively in the white population. Another study showed that the relative frequency of osteosarcoma is higher in China and Japan than in the United States whereas the relative frequency of chondrosarcoma is higher in the American group than in the Asian groups. The incidence of Ewing sarcoma was higher in western people than in Asians whereas the comparative frequency of chordoma is higher in the Americans than in the Asians. The incidence of giant cell tumor of bone is higher in the Chinese and Japanese than in the Americans.

Very little is known about differences in survival of sarcomas along racial lines, but most studies of sarcomas do not show significant differences. In one study of 5,623 cases of soft tissue sarcoma reported in white and African Americans living in the United States, 574 cases (10.2%) were reported in African Americans. A higher percentage of patients with recurrences were reported in whites with liposarcoma (37.7% compared to 28.9% in African Americans), and leiomyosarcoma (45% in whites compared to 39.1% in African Americans). On the other hand recurrences were more frequent in fibrosarcoma and rhabdomyosarcoma in African American patients. No significant differences in survival was found between white and African American patients with soft tissue sarcoma. A study by Huvos showed that for osteosarcoma there were no differences in the survival of African American as compared to white patients. In children with rhabdomyosarcoma, patients from ethnic minority groups more often have larger, invasive tumors with positive lymph nodes at presentation. Nevertheless, they have benefited as equally as white children from the dramatic improvement in survival due to better chemotherapy regimens for rhabdomyosarcoma.

Racial disparities in delay in diagnosis does not seem to be a factor in outcomes of sarcoma treatment in children as one study showed that differences in time to diagnosis related to race were significant only for children with osteosarcoma (p = 0.02), for which white children had longer lag times.

A study looking at soft tissue sarcoma in the upper extremity showed that while whites patients average incidence rate is significantly higher than African Americans and men are at a significantly higher risk compared with women. African-Americans, compared with white patients, were significantly less likely to receive adjuvant radiotherapy. Based on the results of this study, the use of adjuvant radiotherapy was increasing but African Americans were less likely than whites to receive this treatment.

Some of these observations are probably due purely to cultural issues. Unfortunately, there is not much data on cultural and gender differences in tumor outcomes in sarcoma patients, but we may learn from what is known elsewhere in oncology. For Prostate cancer, racial differences in treatment outcomes have been related to socioeconomic status, quality of care, co-morbidities and dietary factors. African American men with metastatic prostate cancer have a worse prognosis than white men and that were not accounted for by known prognostic variables. In one study, race was an independent predictor of therapeutic outcome in androgen-independent metastatic prostate cancer. Similarly, numerous studies have reported a more advanced stage of breast carcinoma at diagnosis in racial/ethnic subgroups, especially among women from African American, Hispanic, American Indian, and native Hawaiian cultures. African American women are more likely to die from breast cancer than Caucasian women. Factors associated with advanced stage at diagnosis in multicultural populations include the basic biological characteristics of the tumor at the molecular and cellular level, complex behavioral attributes unique to a particular multicultural population, and societal issues such as access to care and socioeconomic conditions, all of which impact on the stage at diagnosis. Other data suggests that African American women, compared to white women, are less likely to participate in regular breast cancer screening. The belief that a diagnosis of cancer will result in death has been identified as a potential barrier to cancer screening in African American population groups. Systematically integrating culture into tailored cancer prevention and control interventions (e.g., mammograms for breast cancer screening) may enhance their effectiveness in diverse populations. Socio-economic status appears to be related to breast carcinoma incidence, mortality, and survival rates, but there is a lack of data regarding the status of cancer patients which limits our understanding of the contributions of socioeconomic status to cancer incidence and mortality rates.

Cancer control research is an important part of the stated commitment to reduce cancer incidence, morbidity, and mortality and to increase health-related quality of life. Ethnic minorities are often underrepresented in cancer burden, yet underrepresented in research.

Latino immigrants are also at higher risk of death from breast and cervical cancer, necessitating effective cancer education interventions. Finding a systematic approach to incorporating and embracing societal and cultural perspectives and constructs may effectively appeal to diverse Latino immigrants in the development of a cancer education intervention.

What does any of this have to do with orthopaedics? There does not appear to be a poorer survival in minority sarcoma patients compared to whites, but there are other aspects of care that could probably be improved by understanding gender and racial issues. Learning cultural norms and understanding how to communicate better with patients from multiple cultural backgrounds (culturally competent care) is likely to improve the experience for the patient and the physician. For instance it is important to recognize that efforts to find the best way to reveal (or perhaps conceal) a cancer diagnosis from a patient must recognize that the language between doctor and patient is constrained by cultural norms. Communication is likely to be far less dependent upon the specific words used (e.g., the “C” word) than upon the meaning that is conveyed by the doctor.

In the USA, African Americans are more likely to develop cancer than any other ethnic group. There is also further evidence that African American, Filipinos and Native Americans have the lowest cancer survival rates in the USA. Although this does not appear to be true for sarcomas, reasons for these variations should be understood and probably include cultural, materialist and social explanations as well as the effects of race and genetic disposition. This is an area where more research is needed, in particular learning about cultural beliefs about cancer. Further research into this area should apply culturally competent methods to ensure valid data to inform cancer policy, education and practice.

Review of Some Orthopaedic Health Disparities

RAYMOND O. PIERCE, JR., MD  
FRIDAY, JULY 7 • 9:00 - 9:15 AM

Inequality of musculoskeletal care among certain ethnic and racial groups exists in this country. This occurs in spite of adequate insurance coverage, access and other factors. Disparities of the musculoskeletal system have not received the same attention in the literature that cardiovascular and other systems have. In this presentation we will document four disparities, define their root causes and share the development of meaningful interventions. The conditions that we will discuss are: (1) total joint arthroplasty, (2) diabetic lower extremity amputations, (3) rehabilitation following strokes and (4) morbidity following unintentional injuries.

Methods:

After the entity was documented as a disparate condition, a literature review was carried out. To establish the root cause; the Morehouse Research Center on Health Disparities “social determinants of health” were used. The studies were grouped into the following categories: socio-economic, racism, culture and quality care & biology. We then used the framework suggested by Brownson et al as a guide for developing evidence based public health guide lines.
FINDINGS:

**Total Joint Replacement.** Medicare data along with findings from two N.I.H Consensus Development conferences have all reported the decreased utilization of total joint arthroplasty by Minorities. The level of evidence from most of the studies suggested; bias, stereotyping, prejudice and clinical uncertainty on the part of providers as being the primary factors accounting for these differences. The intervention being developed will deal not only with providers, but also other members of the health care system.

**Diabetic Amputation.** The two fold amputation rate in diabetic minorities has been substantiated by the NHANES Epidemiological study as well as by several studies funded by the Agency for Health Care Policy and Research. Race-specific difference in endothelial function which is at fault in diabetic foot ulceration has been recently demonstrated. There are now two pharmaceuticals which can reverse these cellular abnormalities which will be placed in clinical trials.

**Stroke Rehabilitation:** The Agency for Health Care and Research have documented that blacks are twice as likely as whites to have a stroke, they occur at an earlier age, and blacks on the whole have more neurological involvement at the time of admission. While the rate of rehab may be similar while hospitalized, there is a lag at one year post stroke. There appears to be biological factors involved in the etiology, presentation and a longer recovery trajectory. The interventions will deal with the aggressive post hospital rehab.

Unintentional injuries include the following: motor vehicle and motorcycle accidents, falls, fires, drowning and firearm mishaps. They are the leading cause of years of potential life lost. CDC has strong documentation attesting to the high incidence in minorities as well as the poorer out come in these cases. Social economic factors play a major role in the cause of most of the injuries. Interventions have been put in place by the Center of Injury Control and Prevention, but these have to be augmented.

**Orthopaedic Surgical Intervention Disparities**

**CHARLES L. NELSON, MD**

**Friday, July 7 • 9:15 - 9:30**

Despite being a global leader with regard to medical advances and having many of the leading medical facilities in the world, the United States ranks near the bottom among industrialized countries with regard to generalized health indices such as infant mortality. There are many hypothesis regarding why we have fallen short. Racial and ethnic disparities clearly play a role in our inability to provide the best care to all of our citizens.

Racial and ethnic health care disparities have been well documented across many fields of medicine, including orthopaedic surgery. African Americans and Hispanics are less likely to receive total knee and total hip arthroplasty procedures than majority counterparts despite a higher incidence of osteoarthritis. Additional documented musculoskeletal health disparities include spine surgery, rehabilitation following cerebral vascular accidents, management of congenital and developmental childhood musculoskeletal and neuromuscular disorders and bone metastasis following prostate cancer. The only area for which under-represented minorities are over-represented with regard to surgical interventions is the incidence of lower extremity amputations during the management of diabetic foot ulcers.

The reasons for many of these disparities have not been fully elucidated. However, according to the Sullivan Commission report, many health disparities are at least partially explained by under-representation of certain minority groups in many aspects of the health care industry. Our inability at this time to provide diversity among our providers further emphasizes the importance of training in culturally competent care.

The importance of diversity and culturally competent care becomes clear when we consider how important the patient – physician relationship is to public health. Preventative medicine is generally more cost effective than management of disease after the fact. In cases where preventative strategies are unable to prevent disease, early medical or surgical management is often associated with better and more cost effective outcomes. However, preventative strategies and early therapeutic interventions require effective communication between the physician and the patient. The patient needs to relate well with his or her physician, as well as understand and trust that individual.

Success in addressing these disparities in health care requires a multimodal approach. The root causes must be identified, and solutions need to be developed and evaluated. Two areas which clearly need to be addressed are recruitment of a more diverse group of health care providers as well as education of existing and future providers with regard to the importance of culturally competent care.

**The Impact of Sex and Gender on Human Adaptation to Challenging Environments**

**SARALYN MARK, MD**

**Friday, July 7 • 10:30 - 11:00 AM**

In order to certify that men and women can live in space, NASA needs to know the physiological changes that occur during space travel. NASA pioneered bed rest studies utilizing healthy humans. Thus far, flying men and women in space has not revealed gender or sex response differences that cause major health concerns. However, with longer duration stays in space, it is increasingly important for NASA to be armed with the knowledge needed to ensure the health and safety of all male and female astronauts. The application of sex based similarities and differences in healthy people are not restricted to space. Nor are these differences inconsequential. Sex based biomedicine is important to exposures and occupations as extreme as the Antarctic, high altitude, deep sea, and to communities as diverse as the military, international aid workers, emergency and rescue workers, the elderly and children. During this presentation, findings from a landmark workshop, developed in partnership with the University of Missouri, will be presented. Six work groups that focused on musculoskeletal, cardiovascular, reproductive, neurovestibular, and immunological systems as well as human behavior were established. Differential studies of men and women in challenging environments are difficult to conduct. The small amount of data from space can be complemented by ground based studies. This workshop was the first step on defining what is required for policy and implementation, resources and infrastructure, and establishing research priorities to fully understand the impact of sex and gender on biomedical science and health.

**Gender Differences in Osteoarthritis of the Hip and Knee**

**MARY I. O'CONNOR, MD**

**Friday, July 7 • 11:00 - 11:15 AM**

Gender differences in hip and knee osteoarthritis (OA) are significant. Women have a higher incidence of OA as compared to men. Furthermore, women have more severe pain and disability than men at the time of joint replacement surgery. Such delay may compromise arthroplasty outcomes as patients with more severe preoperative pain and disability have poorer results as compared to those with lesser symptoms. Current knowledge regarding these gender differences will be presented.

**Ethnic Differences in Osteoporosis**

**PATRICIA THOMAS, MD, MA, FCAP**

**Friday, July 7 • 11:15 - 11:35 AM**

Osteoporosis is a major public health issue in the United States. It is a major cause of death and disability in elderly women. It is common and costly. Advances have been made in awareness, prevention, diagnosis and treatment, however the disease remains a silent and underdiagnosed disease, particularly for those women from certain minority groups in the United States. Disparities in awareness, diagnosis, treatment and outcomes exist across racial/ethnic lines as is true with many of the major illnesses, even though the opportunity for prevention is great.

This presentation will cover the background and significance of osteoporosis in the United States and the ethnic differences in osteoporosis. You will learn:

- Attitudes and beliefs that may contribute to disparities in bone health;
- Differences in awareness, diagnosis and treatment across racial/ethnic lines;
- Biologic factors involved in differences in osteoporosis;
- Unique predisposing factors for variations in osteoporosis among racial lines, and;
- Racial/ethnic differences in outcomes

**Gender-Based Design – An Industry Perspective**

**SHERYL L. CONLEY**

**Friday, July 7 • 11:35 - 11:50 AM**

The diagnoses and treatment of many female gender-dominated diseases such as breast cancer and osteoporosis have benefited from the attention of the medical community, government agencies, private/public foundations, and the general public. However, relatively little gender-sensitive attention
has been given to joint-related disabilities that may be more prevalent in females or which may have a female basis in treatment accessibility or outcome. Arthritis is not an equal opportunity disease process. Arthritis in general favors women who as a result have approximately a 60 percent higher incidence of the condition than men. Rheumatoid arthritis is particularly dominant in women with a 2 to 4 times greater occurrence than in men. This female dominance in arthritis prevalence is caused in part by sex-based biological differences and in part on environmental and social factors such as longer life expectancy and a higher obesity incidence. A convergence of factors suggests that the population subgroup of the black, lower social economic status female has both the highest incidence of arthritis and the poorest expectation for treatment access and outcome. In many ways total joint manufacturers and surgeons have treated women as “little men” who typically received implants from the smaller end of the available size range. However, the orthopaedic industry has recently begun to direct its attention to the special treatment expectations and requirement that the arthritic females possess. Recent studies have identified joint-specific anatomic differences between the male and female population which are now being incorporated into total joint component design. These new designs will have a shape to fit the typical female anatomy. It is expected that these changes will improve the outcome of joint surgery in female patients, which in many cases has lagged that of male patients. Less invasive surgical techniques that have recently been developed can along with other benefits result in less visible scars that can be important to the female population. These less invasive surgical techniques can also provide quicker recoveries, which is also important to women who typically want to maintain their independence. Through improved implant products, surgical techniques and public communication, the orthopaedic industry can and should play a role in improving the care of the arthritic female population.

**Women and Minorities in Orthopaedic Residency Programs**

**Kimberly J. Templeton, MD**  
**Friday, July 7 • 11:50 - 12:00 PM**

**Purpose:**  
To examine the ethnic and gender composition of orthopaedic residency programs, compared to the potential applicant pool (i.e., medical students) at two data collection time points.

**Method:**  
Self-reported data was collected from orthopaedic residents through the American Academy of Orthopaedic Surgeons (AAOS) Diversity Survey, which was distributed in 1998 and 2001. Information on medical students was obtained from the Association of American Medical Colleges’ (AAMC) 2002 publication, “Minority Students in Medical Education: Facts and Figures XII.” Comparisons were made between students entering and graduating from medical school and those in orthopaedic residency programs, in terms of gender and ethnicity. Statistically significant group differences were determined using a chi-square test where appropriate.

**Results:**  
With few exceptions, the percentages of women and underrepresented minorities were statistically significantly lower among those training in orthopaedic residency programs, compared to those same groups in entering and graduating medical school. There were few statistically significant differences when comparing 1998 data to that from 2001.

**Conclusions:**  
Women and underrepresented minorities comprise smaller proportions of orthopaedic residency programs than their numbers within medical school would predict. The percentage of these groups within orthopaedic residency programs has remained constant between 1998 and 2001. Further study is necessary to determine if fewer students of color and women are applying to orthopaedic residency programs from lack of interest, lack of appropriate mentoring and role models, or other factors.

**Health Disparities in Women**

**Joan Y. Reede, MD, MPH, MS**  
**Friday, July 7 • 12:00 - 12:15 PM**

Several musculoskeletal diseases disproportionately impact women and people of color. The Bone and Joint Decade provides a unique vehicle for informing the public about these diseases and for engaging students, particularly female and underrepresented minority students, in considering not only issues of health, but also professional career paths in medicine and research.

**Opinions, Views and Evidence on Causes of Health Disparities**

**John Ruffin, PhD**  
**Saturday, July 8 • 8:00 - 8:30 AM**

The issue of health disparities has become an intriguing topic for many people including scientists, legislators and the health care community. The question that many researchers are attempting to understand is why are specific segments of our population disproportionately burdened with disability, diseases, and premature death? It is clear that there is no single cause for health disparities and that makes it not only a challenging issue to address, but also an exciting research subject. A complex interaction among genetics, biologic, behavioral, cultural, socioeconomic and environmental factors appear to contribute to the cause for the disparity in health among racial and ethnic minority populations, rural and urban poor, and medically underserved populations. Issues of unequal access to care, language and cultural barriers, bias in the clinical encounter and the under-representation of minorities in biomedical research, medical and other health care professions, further increases the complexity of health disparities. This session will examine several perspectives and theoretical models on the determinants of health disparities.

**Understanding and Addressing Racial/Ethnic Disparity in Joint Replacement Utilization: Results from VA-based Research**

**Diane L. Rowley, MD, MPH**  
**Saturday, July 8 • 8:30 - 8:50 AM**

Abstract not available at time of printing.

**Ideas, Perspectives and Evidence on Causes of Health Disparities**

**James N. Weinstein, DO, MS**  
**Saturday, July 8 • 8:50 - 9:10 AM**

Abstract not available at time of printing.

**Views on How to Improve Diversity in Orthopaedic Residency Programs**

**Mark C. Gebhardt, MD**  
**Saturday, July 8 • 9:10 - 9:30 AM**

Orthopaedic Departments and residencies are largely societies of white men. Racial and gender issues have only recently become a concern to the specialty of Orthopaedics and each has its own issues. There are strong imperatives to improve the record of including women and minorities in orthopaedics, although the imperatives for each group may differ.

Orthopaedic surgery residencies have the second lowest percentage of women of all residencies (second only to Thoracic surgery) and an even lower percentage of minority trainees. This does not bode well for our specialty! We have enjoyed having an overabundance of applicants to orthopaedics over the years and have been able to select from the top 10% of the graduating class. Women are, or soon will, exceed 50% of the medical school class, (the percentage has risen from 11.1% in 1970 to 47.8% in 2001 according to AAMC data). In the same time period, the percentage of women in orthopaedic training programs has risen slightly from 0.6% to 9%. This increase is lower than all other surgical specialties in medicine. The percentage of all female residents who chose orthopaedics is 0.6%. Is this a problem? From a selfish standpoint it is: we will lose more than half of our applicant pool unless we find away to attract more women in our training programs.

The issue of minorities in orthopaedic residency programs is even more dismal. A questionnaire distributed to orthopaedic program directors revealed that the percentage of racial/ethnic minority residency positions are significantly lower among African American, 3.6%; Native American, 2.2%; Puerto Rican, 1.2%; Mexican-Americans, 0.8%; and other Hispanics, 1%. The number of white graduates from US allopathic medical schools has decreased soon will, exceed 50% of the medical school class, (the percentage has risen from 11.1% in 1970 to 47.8% in 2001 according to AAMC data). In the same time period, the percentage of women in orthopaedic training programs has risen slightly from 0.6% to 9%. This increase is lower than all other surgical specialties in medicine. The percentage of all female residents who chose orthopaedics is 0.6%. Is this a problem? From a selfish standpoint it is: we will lose more than half of our applicant pool unless we find away to attract more women in our training programs.
Why is this important? It has been shown that students who are exposed to classmates with different life experiences and cultures change their prior assumptions and they discover what they and their classmates have in common and how they differ. White male students learn for their female and minority peers to interact better with female and minority patients, which increases the quality of care and the satisfaction of both patient and physician. The AAOS is focused now on education in communication for Fellows and residents to improve our ability to positively interact with patients. Having a diverse faculty and residency class furthers this effort. Affirmative action or tools like it increase the likelihood that a program will have the cultural diversity it needs teach students to fully participate in this country’s heterogeneous democracy. There is a mal-distribution of orthopaedic care in this country with rural and inner city populations being underserved. It is well documented that minority graduates are more likely to choose these geographic areas and be accepted into them than their white counterparts.

What can we do to change the status quo? Certainly it is a multifaceted issue. We need more female and minority role models in our universities and residency training programs. We, as a society, need to expand the applicant pool by improving K-12 education for minorities and to encourage them to enter the medical field. Medical schools need to promote women and minorities for all residency programs and expose medical students to fields such as orthopaedics in their formative years so that they consider them as possibilities when they chose a residency. Some form of affirmative action program is needed at least in the short term to increase the diversity of our orthopaedic residency programs and faculty. Some orthopaedic residency programs such as Harvard and Johns Hopkins have taken steps to do this without changing the quality of the graduate. It requires the commitment of the Chairman and/or program director and a focus on more than grades and MCAT scores during the admission process. It can – and must – be done.

Opinions, Views and Evidence on Ways to Eliminate Health Disparities

JOHN RUFFIN, PhD

The issue of health disparities is complex given the interaction of factors that are believed to contribute to the cause. The impact on every aspect of an individual, community, or country’s existence, warrants the commitment of everyone to eliminate health disparities. Issues of education, training, cultural and linguistic factors, insurance coverage are only some of the issues that must be addressed to effectively conquer the underlying health disparities challenges. It is important to recognize that it is not a problem of the affected communities such as racial and ethnic minorities, the poor, or medically underserved populations; it is our problem as a global community. This session will look at the history of health disparities and how data, programs, and outreach can be employed to foster strategic partnerships to eliminate health disparities.

How to Reduce Health Disparities in Underserved Populations

LOUIS W. SULLIVAN, MD

Abstract not available at time of printing.

Perspectives on Solutions to Decrease Health Disparities

RICHARD A. WILLIAMS, MD

It is axiomatic that poor delivery of health care begets poor health status, and it should be accepted as a dictum that substandard healthcare delivery to certain population groups will result in differences in the clinical profile of the health status of individuals within those subgroups, e.g., members of minority communities. Over the years, the weight of the evidence has established that these observations regarding health status are true. In other words, it is well documented that minority group members suffer more illness, receive worse care, and have worse outcomes than others in our society.

However, this is not the pivotal issue placed before us today. If we acknowledge that there are true differences in health status between certain groups, we must perform investigate why these differences occur. This intimates that there may be disparities in the way in which healthcare is delivered.

Thus, we must first make a distinction between looking at health status and healthcare disparities. The first term refers to the diseases to which a group is prone, and the second term refers to an inequitable application of healthcare resources, unequal access to care, and possible malintent regarding the distribution of medical services. We have a good data base on the first item, but getting our arms around the second one has proven problematic. In order to improve the health status of racial and ethnic minorities, we need to identify what disparities exist, determine the mechanism of their causation, indicate who or what is responsible for causing them, and most importantly, strategize a means of eliminating them.

Within the context of this presentation, attention will focus on indicating the causes and on detailing plausible approaches to eradicating disparities. The Institute of Medicine report concentrated rather elegantly on identification and mechanisms of disparities in healthcare; this presentation will attempt to take the struggle to the next level.

Cobb Institute Strategies to Eliminate Disparities

RANDALL C. MORGAN, JR., MD, MBA

SATURDAY, JULY 8 • 11:40 - 12:00 PM

The W. Montague Cobb/NMA Health Institute was launched December 11, 2004, at a press conference at Howard University in Washington, D.C. This was a major event in the life of the National Medical Association and was a result of a commitment by the House of Delegates of NMA at several meetings prior to the launch. The actual unveiling of the Cobb/NMA Institute was made possible by a charitable donation of $750,000 over two years by AstraZeneca. The mission of the Cobb Institute is to study and provide solutions for the elimination of Health Disparities that affect African Americans and others who are poor and underserved. The Vision of the Institute is to become THE repository of information regarding the health of African Americans including statistics, solutions to health disparities and use of best practices to prove the efficacy of these solutions.

In the early days of the Institute, considerable time has been invested in developing the proper infrastructure to allow future growth. The Research Capabilities are being developed in many ways. The overarching goal of the Institute is to attain flexibility which will enable it both to respond to the research needs of the NMA when requested and to benefit from the current research opportunities as they arise (eg. Medicare Part D, Medicaid Reform, Hurricane Katrina destruction and Bioterrorism Preparedness. The Institute has also accepted the responsibility to obtain funding to support these research efforts, often in partnership with other organizations who share similar interests or goals.

The major disease categories for the Cobb Institute to address are Heart Disease, Diabetes, Obesity, Asthma, HIV/AIDS and Cancer (Prostate, Breast and Colon-Rectal). Every effort is made to include NMA physicians in the design and implementation of the research projects that are generated under the name of the Cobb Institute, whether or not there are other research collaborators involved. The Scientific Sections of the NMA form the basis of the research capabilities of the Cobb Institute. Clinical trials performed by these research physicians and their institutions will provide cutting edge data for the Cobb Institute to review, validate and publicize in scientific journals and other forms of communication as deemed appropriate. A major participant in this effort will be the Journal of the National Medical Association (JNMA).

Partnerships with many organizations and academic institutions who share the mission of the Cobb Institute, that is the elimination of Health Disparities, have developed during the past year and have provided numerous opportunities for research, policy development and advocacy. Considerable support has also been generated for the Cobb Institute within NMA as the agenda of the Institute has become more clearly defined.

Ways to Improve Health Provider Diversity

LOUIS W. SULLIVAN, MD

SUNDAY, JULY 9 • 8:00 - 8:30 AM

Twenty-five percent of citizens in the United States are African-American, Hispanic-American or Native American. But, only 9% of nurses, 6% of physicians and 5% of dentists are from one of these minority groups. With the transformations underway in the U.S., demographers project that by the year 2050, there will be no majority population in the United States.

Ideal delivery of health services requires thorough scientific training and cultural competence of the health services provider.
To achieve greater diversity within the health professions will require a broad range of actions sustained over many years, including development of a supportive environment in our health professions schools, more holistic admissions criteria, non-traditional paths to health professions programs, greater use of scholarships, building educational linkages between high schools, community colleges, baccalaureate institutions, graduate programs and health professions schools, as well as counseling and mentoring programs at all levels in the educational pipeline.

Support must come from the educational community, governments (federal, state and local), the business community, the philanthropic community and from the minority communities themselves.

The elimination of health disparities and the improved health of the nation will require a more diverse health professions workforce. The wealth, productivity and global competitiveness of the United States depends upon a healthier population.

Opinions and Recommendations on How to Increase Diversity in Orthopaedic Faculties and Residency Programs

JAMES N. WEINSTEIN, DO, MS  
SUNDAY, JULY 9 • 8:30 - 8:50 AM

Abstract not available at time of printing.

The Challenges of Orthopaedic Department Chairs in Achieving Diversity

RONALD W. LINDSEY, MD  
SUNDAY, JULY 9 • 8:50 - 9:10 AM

Abstract not available at time of printing.

Successful Increase in Orthopaedic Diversity: A Case Study

CLAUDIA L. THOMAS, MD  
SUNDAY, JULY 9 • 9:10 - 9:30 AM

Over the past two decades, there has been an increase in the number of African American and female orthopaedic surgeons, but the number of African American and female orthopaedic surgeons remains disproportionately low when compared to their numbers in the population. Through a conscious effort to provide diversity to the Johns Hopkins orthopaedic surgery program, the number of African American and female residents has significantly increased over the past two decades, and has soared above the national average. African Americans have comprised 22.9% of all residents, and women have comprised 14.3% of all residents. The number of African American residents within the orthopaedic program during any given academic year has been as high as 32% and the number of females as high as 20%. African American and female residents did not receive lower in-training evaluations than other residents, and all who took the ABOS exam were successful.

Why Winners Win: “Are Juries Affected by Ethnicity and Gender?”

LINDA S. CRAWFORD, JD  
SUNDAY, JULY 9 • 10:30 -10:55 AM

It is an unfortunate reality that a high percentage of physicians will, at some time in their career, face a lawsuit and may find themselves in the courtroom. Despite the presumption that juries are biased in favor of injured plaintiffs, physicians win the majority of their trials. Why is that? How do juries really make their decisions? This lecture will explore the research on jury decision making, including what, if any, the role of race and gender play in the process. For those who enter the courtroom, it is essential to understand the power you have to influence the outcome of your trial and why issues of character continue to be paramount with juries.

We will cover the following areas:

- Why is character so essential to juries?
- How do juries determine character?
- Does ethnicity or gender impact the decision making process?
- What does it take to be a winner in the courtroom?
Overview and Perspectives in CCCE

Augustus A. White, III, MD, PhD  
Sunday, July 9 • 12:00 - 12:30 PM

Overview and Perspectives on Culturally Competent Care Education is a presentation that provides a comprehensive summary of the issues involved in this increasingly relevant field. Definitions for complex terms such as “culture” and “competence” are offered as parameters for further discussion. Overview and Perspectives provides answers to common questions regarding the difference between culturally competent care and “good” patient care, and why it is essential that we reduce the current health care disparities experienced by certain members of our society. The medical organizations and legislative initiatives that are currently addressing health disparities and the need for cross-cultural training are detailed. Overview and Perspectives also offers concrete examples of educational initiatives from the Harvard Medical School curriculum, as well as practical suggestions for how individual practitioners can educate themselves and increase their own cross-cultural skills.

Opportunities for Public Policy Impact on Health Disparities

Christopher F. Edley, Jr., JD, MPP  
Monday, July 10 • 8:00 - 8:30 AM

More specific than the sweepingly broad burdens of class and caste, there are many causes of racial disparities in health status and treatment. Among these are unequal treatment and access. From a “civil rights” perspective, what have been the strengths and weaknesses of the classic antidiscrimination paradigm in generating effective legal and policy responses? What possibilities are there for augmenting this classic approach with alternative strategies. For example, one might emphasize professional paradigms, such as “quality” and evidence-based practice protocols. Or, one could apply no-fault regulatory models keyed to measurable disparities. Or, finally, one might use private market and contractual mechanisms. How might law-trained policy entrepreneurs partner with health care professionals to design such mechanisms?

Perspectives on the Origin of the New Jersey Law S-144

Eric Muñoz, MD  
Monday, July 10 • 8:30 - 8:50 AM

New Jersey has become one of the first states to require cultural sensitivity as a requirement for graduation from Medical School. Public Law 192 went into effect in 2004. All of the state’s three medical schools and one osteopathic school have been required to provide cultural sensitivity coursework to its students as a requirement for graduation.

Development and implementation will be discussed.

Race in VA Health Services Research: A Social Construct

Said A. Ibrahim, MD, MPH  
Monday, July 10 • 8:50 - 9:10 AM

The VA health care system is emerging as a national leader in health care reform. To illustrate the rising attention from the public that the VA health care system has received, here is a quote from a recent article in Fortune, “VA hospitals used to be byword for second-rate care or worse. Now they are national leaders in efficiency and quality….” What is less often appreciated by the lay public is that the VA is also a national leader in health disparities research. To illustrate this point, Dr. Ibrahim will present a series of first-generation, second-generation and third-generation health disparities research projects supported by the VA Health Services Research and Development office. Specifically, he will highlight work focusing on identifying, understanding and intervening on racial/ethnic disparities in the utilization of knee and hip joint replacement in the management of end-stage knee and hip osteoarthritis. Dr. Ibrahim will present data showing marked racial differences in knee replacement utilization in the VA system that mirrors what has been previously shown in the private sector and the Medicare patient population. Published work examining potential patient-level factors such as patient preference, knowledge and attitudes regarding joint replacement that might explain in part the observed disparities in joint replacement utilization will be presented. Furthermore, Dr. Ibrahim will present published and some yet to be published data from the VA National Surgical Quality Improvement Program (NSQIP) showing race/ethnic-specific mortality and complication rates following knee or hip arthroplasty.

Lastly, Dr. Ibrahim will briefly review ongoing VA-funded projects to further examine racial differences in joint replacement utilization while assessing possible patient-centered interventions to mitigate this disparity.

The Importance of Genetic and Sociopolitical Perspectives on Health Policy

Perry W. Payne, Jr., MD, JD, MPP  
Monday, July 10 • 9:10 - 9:30 AM

As increasing genetic discoveries continue to redefine the etiology of various diseases and the development of new treatments, there is an ongoing need to quickly translate genetic research into clinical practice. This translation process requires a policy structure which takes into account the implications of how genetic information can be misused and actually harm rather than help patients. The fusion of genetic research and the ethical, legal, and social implications of this research are essential for the development of future health policies which will seek to develop a more equitable health care system in the United States. As the National Human Genome Research Institute embarks on a Gene and Environment Initiative, the understanding of genetics and its implications becomes more important as potential findings from this Initiative are likely to impact future health care practice. This talk will highlight major implications of genetic research for health policy and potential approaches to addressing key sociopolitical problems that genetic research raises.

Concepts and Perspectives on the New Genetic Race Realities

Monday, July 10 • 10:30 - 11:00 AM

There is a growing body of research and expanding number of studies that magnify, identify, explore and critique the benefits and risks associated with using genetic information to address racial disparities in the provision of health care. This research and these studies have created profound and sometimes troubling questions of the medical, moral, ethical, and legal implications of whether and how to explore this new knowledge.

It is incumbent upon members of the medical, legal, scientific and ethical professions to play a collaborative role in determining the potential benefits and abuses of genetic research in addressing the problem of disparity in health care. These discussions can be used to develop appropriate guidelines in determining matters of law, culturally competent medical care and public policy.

Perspectives on the Definitions of Race and the Impact on Health Studies

Said A. Ibrahim, MD, MPH  
Monday, July 10 • 11:00 - 11:20 AM

Recently, the juxtaposition of two powerful scientific movements in the United States, population genetics and health disparities research, has re-ignited a contentious debate on the complex relationships between race and health or disease. A primary focus of the field of health disparities research is on understanding the complex associations between race, health and health care. Stimulated by the ambitious goals of the Healthy People 2010 Initiative launched by the United States Department of Health and Human Services and a landmark report by the Institute of Medicine documenting widespread unequal medical treatment among racial minorities, many health services, social sciences, and public health investigators have come to view race as a social and cultural construct and eschew its use as a biological construct in studies of race and human illness.

Basic differences of opinion on the appropriate way to apply the construct race in biomedical and health services research raise important questions for medical and public health practitioners, scientists, policy makers, and funding agencies committed to advancing both biomedical and health disparities research agenda. These questions are: (1) What are the arguments for and against using a biological definition of race in medical research of common medical conditions? (2) What is the best way to articulate a comprehensive health disparities research agenda? and (3) What are the current and future roles of genetics in advancing the health disparities research agenda? Dr. Ibrahim will put forward for discussion the Pros and Cons of using a biological definition of race in medical research. He will articulate a health disparities research agenda using very specific conceptual frameworks that define race/ethnicity as a social construct. Finally, he will provide few suggestions for the possible role of genetics in advancing the health disparities research agenda.
Early and Current Insights about Race and Medicine

RICHARD A. WILLIAMS, MD        MONDAY, JULY 10 • 11:20 - 11:40 AM

It is now official: the Institute of Medicine's landmark report issued last year, "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care", was an indictment of the medical profession for practicing medicine in a discriminatory, biased, prejudiced manner. It should be quite clear from the report that health disparities are directly associated with a significant excess of morbidity and mortality in those who are principally affected, who happen to be minority group citizens of the United States. It should be borne in mind that this report did not evolve from the NAACP; La Raza, or some other civil rights group; it was the first-ever Congressionally-mandated report on ethnic, racial, and socioeconomic disparities in health care.

Two other developments with relevance to health disparities have emerged within the past three years. The first was the publication of an important book by Byrd and Clayton in 2000 entitled An American Health Dilemma: A Medical History of African Americans and the Problem of Race, which cited what the authors termed the slave health deficit as being the root cause of our current health disparity status. They argue that we must recognize and admit to biases and prejudices which have been present for almost 400 years which still affect physician practice patterns. The second was the initiation of the Healthy People 2010 Program by the office of former Surgeon General David Satcher. The goals of this program involve the elimination of all racial and ethnic health disparities by the year 2010, or at least a significant narrowing of the healthcare delivery gap.

All of the above items form the basis for this lecture, which deals primarily with the historical basis and causes of disparities and focuses on prospective solutions to decrease them.

The Role of Genetics and Sociopolitical Definitions of Race in Clinical Trials

PERRY W. PAYNE, JR., MD, JD, MPP  MONDAY, JULY 10 • 11:40 - 12:00 PM

One approach to classifying human differences is the use of Census racial/ethnic categories. These categories, devised by a political process led the Office of Management and Budget, currently serve as an important framework for how biomedical researchers distinguish humans. As a result, researchers link medical characteristics to these categories, from increased rates of cancer to increased frequencies of various disease related genes. The linkage of Census racial/ethnic categories to medical characteristics triggers the assumption that genetic and thereby physiological differences among racial/ethnic groups may contribute to the differences in medical outcomes or health disparities. This talk will challenge the assumptions of this pervasive mode of thought and provide alternative approaches for classifying humans that are likely to yield a better understanding of the causes of health disparities and how to eliminate such disparities.

FACULTY INFORMATION

SHERYL L. CONLEY

Group President, Americas and Global Marketing and Chief Marketing Officer
Zimmer Corporation

SHERYL L. Conley, 45, is Group President, Americas and Global Marketing, and Chief Marketing Officer, and is responsible for all Western Hemisphere operations including the Zimmer U.S. businesses, Canada and Latin America and all Global Marketing, including U.S. Marketing. She is the Company’s first Chief Marketing Officer (CMO).

Ms. Conley has just completed 22 years with Zimmer. She began in 1983 in Clinical Research and received several promotions in Distribution Planning through 1994. She joined Marketing as a Product Manager, led the VerSys® Hip development project and in 1997 was promoted to Vice President, Marketing, Hips. In 1998 she assumed the role of General Manager, Zimmer Canada, and returned in 2000 with a promotion to Vice President, Global Brand Management and Commercialization. She was later promoted to President, Reconstructive, and more recently, President, Global Products Group, after the Centerpulse acquisition. Ms. Conley holds a Bachelor of Science (Biology and Chemistry) and an MBA from Ball State University (IN).

LINDA S. CRAWFORD, JD

Faculty, Trial Advocacy Course
Harvard Law School

LINDA S. Crawford, JD teaches trial advocacy at Harvard Law School and has been consulting on trials for Harvard and throughout the country since 1985. From 1977 to 1995 she was also an Assistant District Attorney and Assistant Attorney General for the State of Maine, and was one of the first woman homicide prosecutors in the country.

Attorney Crawford was chosen by the United Nations as one of three Americans on a team charged with investigating war crimes in the former Yugoslavia and preparing cases for the War Crimes Tribunal at The Hague.

Ms. Crawford is a Contributing Editor for two publications of the National Law Journal. She is past-president of a national association of attorneys and has been a commissioner for the American Bar Association and Chairman of the Editorial Board of one of its publications. She lectures at Harvard, Stanford and throughout the country.


CHRISTOPHER F. EDELEY, JR., JD, MPP

Dean and Professor of Law
U.C. Berkeley School of Law (Boalt Hall)

Christopher Edley, Jr. joined Boalt Hall as dean and professor of law in 2004 after 23 years as a professor at Harvard Law School. He earned a law degree and a master’s degree in public policy from Harvard, where he served as an editor and officer of the Harvard Law Review. Edley's academic work is primarily in the areas of civil rights and administrative law. He has also taught federalism, budget policy, Defense Department procurement law, national security law, and environmental law. Edley was co-founder of the Harvard Civil Rights Project, a renowned multidisciplinary research and policy think tank focused on issues of racial justice. His publications include Not All Black and White: Affirmative Action, Race and American Values and Administrative Law: Rethinking Judicial Control of Bureaucracy.

Following graduation Edley joined President Carter's administration as assistant director of the White House domestic policy staff, where his responsibilities included welfare reform and social security. He served as national issues director throughout the 1987-88 Dukakis presidential campaign, and as a senior adviser on economic policy for President Bill Clinton’s transition team in 1992. In the Clinton administration, he worked as associate director for economics and government at the White House Office of Management and Budget from 1993 to 1995. There, he oversaw a staff of 70 civil servants responsible for White House oversight of budget, legislative and management issues in five cabinet departments (Justice, Treasury, Transportation, Housing & Urban Development, Commerce) and a diverse group of over 40 autonomous agencies, including: FEMA, FCC, General Services Administration, SBA, SEC, CFTC, EEOC, and the bank regulatory agencies. In 1995 he was also special counsel to the
president, directing the White House review of affirmative action. He returned to the Clinton White House in 1997 as a consultant to the president's advisory board on the race initiative.

From 1999-2005, Edley served on the U.S. Commission on Civil Rights. In 2001, he was a member of the Carter-Ford National Commission on Federal Election Reform. He is currently a trustee of the Russell Sage Foundation and The Century Foundation, and a member of the National Academy of Public Administration, the Council on Foreign Relations, and the executive committee of the advisory board for the Division on Behavioral and Social Sciences and Education of the National Academies of Sciences.

Education: B.A., Swarthmore College (1973) (mathematics); J.D., Harvard University (1978); M.P.P., Harvard University (1978)

**Mark C. Gebhardt, MD**

*Chief of Orthopaedic Surgery*  
*Beth Israel Deaconess Medical Center*

Dr. Mark C. Gebhardt, M.D. is Chief of Orthopaedic Surgery at Beth Israel Deaconess Medical Center and the Frederick W. and Jane M. Ilfield Professor of Orthopaedic Surgery at Harvard Medical School.

Dr. Gebhardt graduated from Bucknell University in Lewisburg, Pennsylvania and studied medicine at University of Cincinnati in the College of Medicine.

Dr. Gebhardt’s professional experience includes a Fellowship in Orthopaedic Surgery at Children’s Hospital in Boston, Massachusetts and a Fellowship in Orthopedic Oncology at Massachusetts General Hospital, Boston, Massachusetts. He is a Member of the American Board of Orthopaedic Surgery.

Dr. Gebhardt was recognized by Alpha Omega Alpha, Medical Honorary, Beta Chapter at the University of Cincinnati in 1974. He was listed among The Best Doctors in America, 2nd Edition in 1994-97 and was recognized by *Boston Magazine* as one of the Best Doctors of 1997.

**Said A. Ibrahim, MD, MPH**

*Associate Professor of Medicine*  
*Division of General Medicine*  
*University of Pittsburgh*

Dr. Said A. Ibrahim graduated from Oberlin College in Oberlin, Ohio and received his M.D. from Case Western Reserve University in Cleveland, Ohio. He was an intern and resident at Brigham & Women’s Hospital, Harvard Medical School in Boston, Massachusetts. He next graduated from Harvard School of Public Health with an M.P.H.

Dr. Ibrahim received several honors including the Highest Academic Prize from Somalia National University from the College of Education in Somalia and the Alpha Omega Alpha Medicine Honor Fraternity from Case Western Reserve University School of Medicine in Cleveland, Ohio. He was twice nominated for the Ambulatory Teacher of the Year Award from the Department of Medicine at University Hospitals of Cleveland in Cleveland, Ohio. In 2000 he received the Career Development Award as a research associate in the Department of Veterans Affairs HSR&D.

Dr. Ibrahim is actively involved in research support including:

- **Racial/Ethnic Disparities in Joint Replacement Utilization and Outcomes** examined the reasons for racial differences in patient expectations on joint replacement outcomes;
- **Understanding the role of race in physician decisions to prescribe opioid analgesia** examined how the patient’s race/ethnicity influenced ER physicians’ decision-making with respect to use of opioid analgesia for pain.

**Ramon L. Jimenez, MD**

*Senior Consultant*  
*Monterey Peninsula Orthopaedic and Sports Medicine Institute*

Dr. Ramon Jimenez went to Santa Clara University for his premedical education, followed by St Louis University School of Medicine. He performed his specialty training at San Francisco Orthopaedic Residency Program. Military service as an orthopaedic surgeon and a major with the 101st Airborne at Fort Campbell, Kentucky pulled him away from California for the last time.

Dr Jimenez has served the heavily populated Latino community of East San Jose by having a large office at Alexian Brothers Hospital.

Dr Jimenez has realized that healthcare disparities exist, particularly with the Latino segment of the population. He knew that the best way to overcome this fact is to provide access to care for them, as well as, providing culturally competent care. He is very aware of this need and responded to it by having bicultural and bilingual staff available for the medical group's patients.

He served on Medicare’s first Physicians Advisory Board after his appointment by Louis Sullivan, M.D., former Secretary of Health and Human Services, under President George H Bush.

Dr. Jimenez was appointed to the Board of Directors of the California Orthopaedic Association, where he has served for over 12 years, including as President. He next served and subsequently chaired the Patient Education Committee, where he had the opportunity to promote and develop Your Orthopaedic Connection. This is a website link for patients to access information regarding diagnosis and treatment of their disease or injury. The best part of this, which he favors, is the En Español section which contains over 50 topics translated into Spanish.

Later Dr Jimenez was elected to the Board of Directors of the Academy. He used this as a springboard to become more involved with the Diversity efforts of the AAOS. He has previously served and now chairs the Diversity Committee. One of its primary charges is to educate the predominately non-diverse membership (19,000) regarding culturally competent care. In California, which enjoys a richly diverse population, there is a manifest need for culturally competent care education. Presently a favorite activity is his contribution as a member of the Board of Trustees of the National Hispanic University.

**Ronald W. Lindsey, MD**

*Department Chair*  
*Professor of Orthopedic Surgery*  
*University of Texas*

Ronald W. Lindsey, M.D. is a graduate of Yale University in New Haven, Connecticut (B.A., Anthropology) and received his M.D. from Columbia University in New York. He performed his residency in Orthopedic Surgery at Yale University.

Dr. Lindsey was also a Professor of Orthopaedic Surgery at Baylor College of Medicine and Former Acting Chairman in the Department of Orthopedic Surgery. His hospital training includes the University of Basel, Basel, Switzerland, AO Fellowship, Trauma/ Internal Fixation, Department of Orthopaedic Surgery, University of Innsbruck, Innsbruck, Austria, the Professor Rudolf Bauer Spine Fellowship, Department of Surgery, Stoke Mandeville Hospital, Bucks, England, Hand and Microvascular Surgery Fellowship, the Department of Orthopaedic Surgery, University of Marseille, Marseille, France, Professor Rene’ Louis, Orthopaedic Traumatology and Spine Surgery, Department of Orthopaedic Surgery, University of Basel, Basel, Switzerland, Professors Edwin Morsch and Harold Dick, Trauma and Spine Surgery, Orthopaedic Surgery Clinic.

Dr. Lindsey is active on the AAOS Committee on Emergency Medical Services; Ben Taub, the Editorial Board of the *Journal of the American Academy of Orthopaedic Surgeons* and is the Chairman of the Continuing Medical Education Committee for Baylor College of Medicine.
Saralyn Mark, MD

National Aeronautics and Space Administration

Saralyn Mark, M.D., an endocrinologist and a geriatrician, is the Senior Medical Advisor to the Office on Women’s Health within the Department of Health and Human Services and the National Aeronautics and Space Administration (NASA). She is also an Associate Professor adjunct at the Yale University School of Medicine in the Departments of Internal Medicine and Obstetrics and Gynecology.

Dr. Mark received her Bachelor of Arts degree with honors in biology from Barnard College of Columbia University and her medical degree from New York University School of Medicine. She completed her internship and residency in Internal Medicine at UCSF. Following private practice in Internal Medicine in San Francisco, Dr. Mark returned to UCSF where she designed and completed one of the country’s first Women’s Health fellowships which may now serve as a national model.

At UCSF, Dr. Mark conducted clinical research studies in the areas of osteoporosis, cardiovascular disease and lipids. Dr. Mark has published and given over 400 lectures nationally and internationally on critical issues in women’s health as well as on emerging technologies. She also continues to teach medical students, residents and nurses. She has made over 100 television, radio and print appearances including CNN, NBC Nightly News, and the Washington Post. Dr. Mark has received many accolades such as the Gynecologic Cancer Foundation’s Public Service Award. Prior recipients of this honor have included Larry King and Barbara Walters.

Dr. Mark is a Diplomat of the National Board of Medical Examiners and is a member of numerous national advisory boards and professional organizations including the President’s Interagency Council on Women, the National Institutes of Health Federal Working Group on Bone Diseases, the NASA Medical Policy Board, the National Committee for Quality Assurance Advisory Panel on Hedis Measurements for Women’s Health, and the Surgeon General’s Physician Advisory Committee. She has served on the United Nation's Global Commission on Women’s Health and the Pan American Health Organization’s Special Subcommittee on Women’s Health. Dr. Mark has chaired the Subcommittee on Exogenous Hormones for the Federal Interagency Working Group on Women's Health and the Environment, the Secretary of Health and Human Service’s National Task Force on Health Professional Education on Female Genital Mutilation, and the National Task Force on Mentoring in Academic Medicine which led to the development of national programs.

As Senior Medical Advisor, Dr. Mark is responsible for the development and analysis of initiatives and programs on sex and gender based medicine and women’s health on Earth and in Space. Additionally, she fosters collaborations between health care organizations and scientific agencies to increase their focus on these important issues.

Randall C. Morgan, Jr., MD, MBA

Vice-President
J. Robert Gladden Orthopaedic Society

Dr. Morgan was born in Gary, Indiana. After graduating from high school as co-Valedictorian, he received a B.A. degree in chemistry at Grinnell College in Grinnell, IA, in 1965. He then received an MD degree from Howard University College of Medicine in Washington, D.C. in 1969. He served an internship at Passavant Hospital in Chicago and completed an orthopedic residency at Northwestern University in Chicago in 1974. He also completed training in Rehabilitation Orthopedics and Rancho Los Amigos Hospital in Downey, California. After ten years of private practice, Dr. Morgan completed a fellowship in Pediatric Orthopedics at Children’s Hospital in Cincinnati, OH. He also received an MBA degree at the University of South Florida, Tampa, FL in 2001.

Dr. Morgan has practiced orthopedic surgery in Evanston, IL and in Gary and Merrillville, Indiana for over 30 years. He founded and was President of The Orthopedic Centers which was an eleven physician orthopedic group in Northwest Indiana. He presently holds faculty appointments at Northwestern University and Indiana University. Dr. Morgan is a past-President of the National Medical Association and the Indiana Orthopedic Society. He is currently the Vice-President of the J. Robert Gladden Orthopaedic Society and was recently appointed as the first Institute Director of the W. Montague Cobb/NMA Health Institute. He is the author of numerous publications and has made over 200 scientific presentations at local, state and national courses and conferences.

In April of 2005, he enthusiastically started a new orthopedic practice in Sarasota, Florida to bring further benefit to the community which had been a vacation home to him and to his wife, Karen, for 25 years. Since relocating to Florida, he has helped to initiate the Gulfcoast Medical Society of the National Medical Association, serving Sarasota and Bradenton. His present academic interests include the study of musculoskeletal health disparities and the use of Trabecular metal in total joint arthroplasty.

Assemblyman Eric Muñoz, MD

Surgeon
New Jersey Medical School

Assemblyman Eric Muñoz, M.D., was sworn into office on May 10, 2001 filling the unexpired term of Assemblyman Kevin O’Toole. On November 8, 2005 he was elected to his third full two-year term representing District 21, which includes 16 towns in Essex, Morris, Somerset and Union counties. From 1995 to 2001 Dr. Muñoz served as Councilman-at-Large for the City of Summit. From 1998 to 2004 he also served as Chairman of the Summit City Republican Municipal Committee.

Assemblyman Muñoz is serving on the Assembly Health and Human Services Committee and the Assembly Commerce and Economic Development Committee in the 2004-2005 Legislative Session. He is also a member of the New Jersey Task Force on Child Abuse and Neglect, the Assembly Latino Caucus as well as a Member of the Board of the National Puerto Rican Coalition. In January, 2006 he will become the Assembly Republican Deputy Conference Leader.

Assemblyman Muñoz graduated from the University of Virginia in 1969. He graduated from Albert Einstein College of Medicine with his Medical Doctorate in 1974; he completed his surgical training at Yale-New Haven in 1979. Dr. Muñoz earned his M.B.A. with a Major in Finance from Columbia University in 1983.

Dr. Muñoz is a Professor of Surgery at the New Jersey Medical School and a Trauma Surgeon at UMDNJ - University Hospital, Newark, NJ. He also serves as President of the Medical Staff. He is one of the first physicians to become actively involved in health delivery costs, quality and management as an academic discipline. From 1990 to 2001 Dr. Muñoz served as Chairman, of the Medical Practitioner Review Panel for the State of New Jersey having been appointed by former Governor Jim Florio and reappointed by Governor Christie Whitman.

In June, Dr. Muñoz completed his term of service on the National Advisory Council on Minority Health and Health Disparities of the National Institutes of Health, he was appointed by United States Secretary of Health and Human Services, Tommy G. Thompson. In 1992, Dr. Muñoz was appointed by President George H. Bush to the 45th World Health Organization Assembly in Geneva, Switzerland.

Assemblyman Muñoz resides in Summit with his wife, Nancy and their five children.

Charles L. Nelson, MD

Assistant Professor in Orthopaedic Surgery
University of Pennsylvania Health System

Charles L. Nelson, M.D. is an Assistant Professor in the Department of Orthopaedic Surgery at the University of Pennsylvania Health System. His areas of expertise include complex hip and knee reconstruction, primary and revision total hip and knee replacement, and hip and knee arthroscopic surgery. His special interests include investigating the root causes and potential solutions for ethnic health disparities particularly as they apply to total joint replacement, evaluating less invasive techniques for performing primary joint replacement, and evaluating techniques to restore bone stock or obtain fixation during complex revision hip and knee replacement. His research involves investigation of the causes of ethnic musculoskeletal health disparities as they apply to total joint replacement, management of knee and hip problems in hemophiliac patients, improving surgical techniques for management of fractures around hip and knee replacements, and evaluating potential advantages of less invasive techniques for hip and knee replacement.

He has received the Medical Society of Eastern Pennsylvania Award for Outstanding Leadership, Achievement and Community Service and the Charles Drew Award for Leadership and Service. He was a Minority Health Faculty Scholar at the Center for Excellence on Minority Health, University of Pennsylvania School of Medicine, and was cited in the Philadelphia Magazine “Top Docs,” Orthopaedic Surgery (Hip/Knee).
Professor Charles J. Ogletree, Jr.

Harvard Law School Jesse Climenko Professor of Law


He is the co-author of the award-winning book, *Beyond the Rodney King Story: An Investigation of Police Conduct in Minority Communities*, and he frequently contributes to many journals and law reviews. He has written chapters in several books, including “If You Buy the Hat, He Will Come, in Faith of Our Fathers: African American Men Reflect on Fatherhood” and “The Tireless Warrior for Racial Justice,” which appears in *Reason & Passion: Justice Brennan’s Enduring Influence. Privileges and Immunities for Basketball Stars and Other Sport Heroes?* and in *Basketball Jones*, published in 2000. In addition, Professor Ogletree’s commentaries on a broad range of timely and important issues have appeared in the editorial pages of the *New York Times*, the *Los Angeles Times*, and the *Boston Globe*, among other national newspapers. His commentary on how to make Black America better was published in the 2001 compilation, *Lift Every Voice and Sing*.

Professor Ogletree also serves as the Co-Chair of the Reparations Coordinating Committee, a group of lawyers and other experts researching a lawsuit based upon a claim of reparations for descendants of African slaves, along with Randall Robinson, author of *The Debt: What America Owes to Blacks*.

Earlier this year, Professor Ogletree was honored with the Dr. Martin Luther King, Jr. Legacy Award for National Service, and presented with the Morehouse College Candle in the Dark Award in Education and Law. In 2004, the Clio Exchange presented Professor Ogletree with the Carter G. Woodson History Maker Living Legend Award. In 2003, he was selected by *Savoy Magazine* as one of the 100 Most Influential Blacks in America and by *Black Enterprise Magazine*, along with Thurgood Marshall, A. Leon Higginbotham, Jr., and Constance Baker Motley, as one of the legal legends among America’s top black lawyers.

E. Anthony Rankin, MD

AAOS Second Vice President

Howard University

Orthopaedic surgeon E. Anthony Rankin, MD, was elected Second Vice President of the Board of Directors of the American Academy of Orthopaedic Surgeons (AAOS) at the organization’s 73rd Annual Meeting, held March 22-26, 2006, at McCormick Place in Chicago.

A graduate of Lincoln University in Jefferson City, Mo., and the Meharry Medical College in Nashville, Tenn., Dr. Rankin completed his internship and residency at Walter Reed Army Medical Center, and is currently Chief of Orthopaedic Service at Providence Hospital, Clinical Professor of Orthopaedic Surgery at Howard University College of Medicine and Clinical Associate Professor at Georgetown University School of Medicine, all located in Washington, D.C. Dr. Rankin specializes in adult reconstruction and hand surgery.

“As the first African-American in the presidential line of the AAOS, it is an honor to help carry out the Academy’s mission which includes promotion of diversity within orthopaedics,” Dr. Rankin explained. “I am committed to supporting the Academy’s new governance structure, and to furthering the needs of our members and patients through our student mentoring and Leadership Fellows Program, as well as via advisory boards on diversity and women’s issues.”
**Diane L. Rowley, MD, MPH**  
**Director of the Research Center on Health Disparities**  
**Morehouse College**

Dr. Diane L. Rowley received her B.A. from Wellesley College in Wellesley, Massachusetts. She earned her M.D. from Meharry Medical College in Nashville, Tennessee and served a Pediatric Residency at the Medical College of Virginia in Richmond, Virginia.

Dr. Rowley was an Epidemic Intelligence Service Officer for the Centers for Disease Control in Atlanta, Georgia and worked in a Preventive Medicine Residency for the Centers for Disease Control. She has a Masters in Public Health from the Harvard School of Public Health in Boston, Massachusetts.

Dr. Rowley is the founding Director of the Research Center on Health Disparities at Morehouse College. The Center conducts interdisciplinary research that integrates social, cultural, psychological and biological dimensions of health. The Center works with partners to develop theory-based, culturally-specific, community participatory research and provides seminars on a range of public health topics, with special emphasis on Public Health Ethics, Community Participatory Research, and Social Determinants of Health.

Dr. Rowley spent ten years (1987-97) in the Division of Reproductive Health in the National Center for Chronic Disease Prevention and Health Promotion. She served as Chief of the Infant Health Section of the Pregnancy and Infant Health Branch, then as Deputy Branch Chief of the Pregnancy and Infant Health Branch.

Dr. Rowley is a member of the Alpha Omega Alpha Honor Medical Society. She has received numerous awards from the CDC and the US Public Health Service, including the CDC Group Honor Award, Operational Research, the US Public Health Service Outstanding Service Medal, and the Hildrus A. Poindexter Award of the Black Commissioned Officers Advisory Group.

Her most recent contribution has been to the *Handbook of Black American Health: Policies and Issues Behind Disparities in Health.*

**John Ruffin, PhD**  
**Director**  
**National Center on Minority Health and Health Disparities**

Dr. John Ruffin is the Director of the National Center on Minority Health and Health Disparities. He is a well-respected leader and visionary in the field of health disparities. He has devoted his professional life to improving the health status of minority populations in the United States and to developing and supporting educational programs for minority researchers and health care practitioners. His success has been due in large part to his ability to motivate others and gain the support of key individuals and organizations, as well as to his expertise in strategic planning, administration, and the development of numerous collaborative partnerships.

For over 15 years, he has led the transformation of the NIH minority health and health disparities research agenda from a programmatic concept to an institutional reality. He has served as the Associate Director for Minority Programs, Office of Minority Programs; and the Associate Director for Research on Minority Health, Office of Research on Minority Health. As the NIH federal official for minority health disparities research, through multi-faceted collaborations, he has planned and brought to fruition the largest biomedical research program in the nation to promote minority health and other health disparities research and training. He has spearheaded the development of the first comprehensive Health Disparities Strategic Plan at NIH. His efforts have impacted local, regional, national and even international communities and have resulted in a growing portfolio of:

- Research, training, and capacity building programs;
- Health professionals and scientists of racial/ethnic minority populations;
- Centers of Excellence conducting cutting-edge health disparities research;
- Endowment awards to academic institutions, and;
- Community-based participatory research initiatives

Dr. Ruffin has been committed to conceptualizing, developing and implementing innovative programs that create new learning opportunities and exposure for minority and health disparity students and faculty, as well as minority-serving institutions. In his quest to eliminate health disparities, the hallmark of his approach is to foster and expand strategic partnerships in alliance with the NIH Institute and Center directors, various Federal and state agencies, community organizations, academic institutions, private sector leaders, and international governments and non-governmental organizations.
Kim Templeton, MD is associate professor of orthopaedic surgery at the University of Kansas Medical Center. She is director of the orthopaedic residency education program. Dr. Templeton is the first McCann Professor of Women in Medicine and Science at the University of Kansas School of Medicine and is president of the Women in Medicine and Science Program. Dr. Templeton received her medical degree at the University of Missouri-Columbia School of Medicine. She completed her orthopaedic surgery residency at Rush-Presbyterian-St. Luke’s Medical Center in Chicago, Illinois and a fellowship in orthopaedic oncology at the Harvard Combined Program.

Claudia L. Thomas, MD
Tri-County Orthopaedic Center, Florida

Dr. Claudia Thomas is the first African America female orthopaedic surgeon in the country. She was born in Brooklyn, New York and attended the High School of Music and Art in Manhattan. Perfect scores in algebra and geometry earned her Regents and National Merit Scholarships. She attended Vassar College, where she was President of the Student’s Afro-American Society. Her senior thesis was a study of sickle cell anemia in the Poughkeepsie Community.

Dr. Thomas received her M.D. degree from The Johns Hopkins University School of Medicine. In all of the orthopaedic residency programs to which she applied, she would have been the first female resident. She completed her orthopaedic residency training at Yale and in 1980 became the first female graduate of the Yale Orthopaedic Program and the first African American female orthopaedic surgeon in the country. Dr. Thomas then completed a fellowship in trauma at the Shock Trauma Unit of the University of Maryland Medical School.

Following her trauma fellowship, Dr. Thomas was appointed Assistant Professor of Orthopaedic Surgery by The Johns Hopkins University School of Medicine. She trained orthopaedic residents at the Baltimore City Hospitals for a number of years. In 1985, she moved to St. Thomas in the Virgin Islands where she worked in a government hospital and developed a private practice. Illness with increasing renal failure interrupted her professional activities. She had surgical removal of both kidneys and eventually received a donor kidney from her sister in 1991. She has done well medically since.

Dr. Thomas returned to Baltimore as Assistant Professor in the Johns Hopkins Department of Orthopaedic Surgery. In 2004, Dr. Thomas joined two of her former mentees in a private practice located in central Florida, a situation that she describes as the best professional years of her life.

Dr. Thomas has been inducted into the Alpha Omega Alpha Honor Medical Society of the Johns Hopkins University. She has received the Unsung Hero Award from the Baltimore Branch of the NAACP, the Living Legend Award from the Great Blacks in Wax Museum, Baltimore, MD and the Woman of the Year Health Services Award from the Zeta Phi Beta Sorority, Inc., Alpha Zeta Chapter. She has been featured as a guest speaker on the Hour of Power Broadcast, Crystal Cathedral Ministries. Dr. Thomas has also been featured in the Baltimore Afro-American Newspaper, Orthopaedics Today, The Baltimore Times, Health Quest, Gospel Today, Essence Magazine, Black Enterprise Magazine: "America’s Leading Black Doctors," Smart Woman Magazine and Style Magazine. Dr. Thomas was also featured in 365 Days of Black History 2002 Engagement Calendar. Her autobiography, God Spare Life, is in press.
Gothenburg and at the Karolinska Institute, where he obtained a PhD for research on the biomechanics of the spine.

He later returned to Yale Medical School and became a Professor of Orthopaedic Surgery and Director of the Engineering Laboratory for Musculoskeletal Disease, a currently active laboratory that he was instrumental in founding. He was recruited to Beth Israel Hospital to start its first Orthopaedic Department. In collaboration with a colleague at Beth Israel, Dr. White originated that hospital's Orthopaedic Biomechanics Laboratory. He has trained twenty-five spine surgeons in the Daniel E. Hogan Spine Fellowship Program, of which he was the Director.

Dr. White was a member of the Brown University Board of Fellows for 11 years and a past Alumni Trustee of Northfield Mount Hermon School. He is a current Trustee at WGBH Radio/TV and is on the Board of Directors of the Partnership both in Boston.

Dr. White has committed himself to issues of diversity and is nationally recognized for his work in medical education, and issues of health care disparities. He is the founding President of the J. Robert Glidden Orthopaedic Society, a multicultural organization. He is committed to the society's mission to eliminate musculoskeletal health disparities. Dr. White was guest Editor of the journal, Clinical Orthopaedics and Related Research, which published a symposium on “Issues of Minorities in Medicine and Orthopaedics.”

Dr. White is the past Chairman of the American Academy of Orthopaedic Surgeons Diversity Committee and is the Chair of the Harvard Medical School Committee on Culturally Competent Care Education. Dr. White has served at the National Institutes of Health as a member of the Advisory Council of the National Institutes of Arthritis, Diabetes, Digestive and Kidney Diseases. He currently serves on the National Advisory Council of the National Center on Minority Health and Health Disparities.

**Augustus A. White, III, MD, PhD**

**Ellen and Melvin Gordon Professor of Medical Education**

**Professor of Orthopaedic Surgery**

**Harvard Medical School**

Dr. Augustus White is a scientist who has distinguished himself on several fronts, most notably orthopedics. He was the Orthopedic Surgeon-in-Chief at Beth Israel Hospital in Boston, Massachusetts for thirteen years. Today he is the Ellen and Melvin Gordon Professor of Medical Education, Professor of Orthopaedic Surgery at Harvard Medical School (HMS) and Professor in the Harvard/MIT Division of Health Sciences and Technology. He is currently Master of the Oliver Wendell Holmes Society, HMS.

Dr. White attended Stanford Medical School where he served as student body President during his fourth year. It was at Stanford that he became interested in the problem of back pain. Following graduation, he honed his skills at University of Michigan Medical Center as an intern, then at Presbyterian Medical Center, San Francisco where he was a general surgery resident.

Dr. White went to Yale Medical Center, where he completed his orthopaedic residency. He then joined the U.S. Army Medical Corps and served for two years. Following this he studied at the University of
We apologize for any oversight, deletion or misspelling.

Any such occurrences were unintentional.

- JRGOS Staff
Lausanne, Switzerland
July 6 – 10, 2006

J. ROBERT GLADDEN ORTHOPAEDIC SOCIETY
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