# Diversity and Professional Excellence

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There are compelling moral and practical reasons why the memberships in professions should mirror the populations that they serve. In order to address this general issue more exactly, this essay will confine itself to a particular case as an emblem for the general point. The particular case is the profession of orthopedic surgeons in the United States. From an examination of this specific case, it is hoped that more general issues of racial, ethnic, and gender fairness within the professions will also be addressed.

**Key words:** African Americans ■ minorities ■ women ■ diversity ■ professional ethics ■ residency admissions ■ orthopedic surgery

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## INTRODUCTION

To begin, it is important to introduce the two authors of this paper. Richard Grant is an orthopedic surgeon with national credentials serving on numerous governing boards. Michael Boylan is a philosopher who has written on medical ethics. The two of us began this paper over a year ago in various discussions we had together and decided that given what we feel is an increasingly hostile climate to minorities in the United States, it was time for those who felt differently to speak out.

Our argument is rather simple in design. We intend to show that there are moral and prudential justifications for proportional diversity within the professions in general and among orthopedic surgeons in particular. After setting out these arguments, we suggest several first steps toward the implementation of our prescription.

## SECTION ONE: THE MORAL ARGUMENT FOR PROPORTIONAL DIVERSITY

In this section of the paper, two aspects of the moral argument will be explored. First, a general moral argument will be presented on the basis of merit considerations. Second, an argument based upon professional ethics will be put forth.

### General Moral Argument for Proportional Diversity

Some opponents to the goal of proportional diversity often put forth the argument that the individuals who do not make medical school or those who are not accepted into a residency program in orthopedic surgery do not merit it. They are losers in the competition of life. They *deserve* to fail. Those promoting this position often say that merit must be based upon past actions and not upon some sort of social, utopian goal. Who do you want holding the scalpel—a person whose actions have shown his excellence or some other individual that acquired his position based upon some sort of legalistic quota? For simplicity sake, let us label this position as merit$_1$ ($m_1$).

The authors wish to refute the aforementioned position based upon a slightly different model of merit. We agree that merit should be based upon past actions. However, how are these past actions measured? $M_1$ asserts that they are interested in actual work performed to judge an individual's merit. However, it seems to us that this is not the case. Really, what $m_1$ wants to assert is that some sort of positioning on the majority population's grid marks work performed. This is not necessarily indicative of merit.

In order to explain this, let us examine the argument via the model of the puzzle-maker. In this thought experiment, any given period of life (a subcategory of life—such as preparing for one's life profession as an orthopedic surgeon—or the whole of one's life) can be thought of as putting together a puzzle. Now, anyone who has worked at puzzle-making knows the early stages of puzzle creation are the hardest. One has to assemble the border and then organize the thematic and color combinations in a general, holistic fashion. This is very time-consuming. Most aspiring puzzle-makers fail during this stage.

As one progresses in the puzzle-making process, things become easier. The final 10% is really a breeze.

Now, what if life were really like puzzle-making? Some people enter life with very little if any of the puzzle completed for them. In these situations, most fail. Others are given a 40%, 60%, or even an 80% completed puzzle. This dynamic means that for those individuals they must only complete the rest. Now, let us try to compare two individuals at the extremes. Person A was given only 10% of her puzzle at birth and when she finished high school she had completed 50% of the puzzle. She is up against Person B who was given an 80% completed puzzle at birth. B had a calm and supportive domestic life, two hard-working, supportive parents, comfortable income, and a biological make-up that was free from chemically imbalanced mental afflictions. With so much oversight and environmental and natural advantages, it's no wonder that B went from 80% to 87.5% in his precollege years. However, when evaluating the two candidates, which one really *did* more?

The $m_1$ group would say Mr. B. They would point to the differential between 50% and 87.5% on society's grid. However, the authors of this essay suggest that Ms. A has demonstrated greater merit because she went from 10% to 50%. This indicates that by her own actions alone she accomplished 40%; whereas B, by his own actions, only achieved 7.5%.

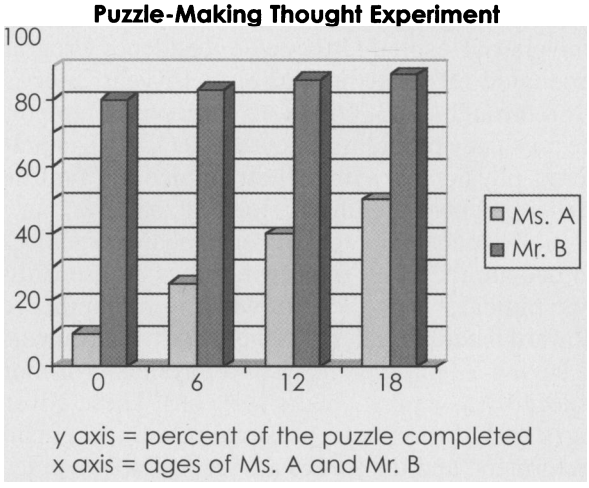
Obviously, this is a case at the extremes. However, it is put forth to make an abstract point about merit. Some people have natural advantages of environment that can include some or all of the following when it comes to the ability to enter a profession:

- Adequate food, clothing, shelter, and protection from unwarranted bodily harm
- Basic educational opportunity
- Being treated with dignity and love for who you are
- A nurturing home environment
- Parental models for patterning behavior (that the society views positively)
- Freedom from disabling disease whether it be mental or physical
- Inside connections affecting admission to universities and to the professions
- Affluence

Obviously, this list could go on and on. But when Mr. B speaks with hubris about how he has become a partner in the accounting firm, it may be important to know that Mr. B's father is the senior partner in the firm and got B his job in the first place (and has been holding B's hand all his life). This is the life of preferment that allows parents to present to their children, ceteris paribus—a puzzle that is 80% complete. All the child has to do is not to screw up too badly and he's set for life.

This preferment list need not merely include socioeconomic factors. Race and gender are also factors. For example, in a profession that is not representative of society's diversity, one will (by definition) find an over-representation of some other group. Let it be assumed that this over-represented group is comprised of white males. And let it further be assumed that unreflective members of that group, without actual malice, simply imagine that the typical member of said profession is a white male. In this case, a clique is created that seeks its own continuation (as all cliques do). Thus, the practitioners of the profession put up barriers that create "old boys club" expectations that have the effect of excluding all others outside of that model. If such

**Figure 1. Merit Measured by the Puzzle-Making Thought Experiment**



assumptions are correct, then on the puzzle-maker example, being a white male seeking to enter that profession is to possess (whether one seeks it or not) a preferment: a significant part of the puzzle completed for him. This is *not* success by merit; it is success by unmerited preferment.

In the case of orthopedic surgeons, medical school admission data shows that the percentage of under-represented minorities, i.e., African Americans, Hispanics, Native Americans, Puerto Ricans, and Mexican-American orthopedic residents (those accepted into orthopedic residency training and retained in the five-year postgraduate residency educational experience) has remained unchanged for 12 years (1987 through 1999) and beyond. When we say beyond, this is to imply that the statistics have not improved since 1999. By contrast, the percentage of Asian and Pacific Islander men quadrupled during the same time interval and beyond (2.2% in 1983 to 9.8% in 1995). The percentage of white women admitted to and retained within orthopedic residency education programs remained the same. The statistical representation of white males in orthopedic residency programs mirrors (by direct relationship) the level of participation of Asian or Pacific Islander males (i.e., as one increases the other decreases).

During the past 11 years, 1988 through 1999, the Howard University Hospital Division of Orthopedic Surgery in Washington, DC Orthopedic Residency Education Program has graduated 60 physicians. The graduating surgeons were overwhelmingly African-American, African, or of Caribbean descent. Greater than 90% of those graduating from the Howard University Orthopedic Residency Education Program passed the American Board of Orthopedic Surgery Qualifying Examinations, Part I and II (written and oral) on the first attempt. The Accreditation Council of Medical Education, which determines residency standards, requires a 75% board passage rate for first-time takers. Howard University Hospital Orthopedic Residency Program graduated 60 residents during a 15-year interval, 1988 through 2003. Of the 60 surgeons completing the residency program, six out of 60 (10%) had practicing physicians within their immediate families (either parents or siblings). However, only two out of 60 (3.3%) counted practicing orthopedic surgeons as immediate members of their families. These statistics indicate that the overwhelming number of Howard medical students do not have the advantages of having a family member as a physician (or more especially as an orthopedic surgeon). These advantages include contacts, personal references, inside preferment, and the sort of advice that only a practitioner can provide. This means that these candidates at Howard have more of the puzzle that they must construct by themselves.

One must consider that the application process for entry into any of the 152 orthopedic postgraduate residency education programs is a highly competitive adventure. The challenge is especially daunting for women and under-represented minorities who are often not considered "coin of the realm" ideal candidates for the white-male-dominated close-knit culture represented by current academic orthopedic educational centers. Consider also a recent publication by Adam D. Bernstein, L. Jazrawi, B. Elbeshbeshy, C. Valle, and J. Zuckerman. The article approached the subject by surveying orthopedic residency program directors by mailing to the 156 orthopedic surgery residency education programs throughout the United States. The top 10 criteria identified in rank order included:

1. The applicants secured a surgical rotation (elective rotation quite similar to an audition) at the program director's institution.
2. High USMLE Part I score.
3. The candidate's rank in medical school.
4. Formality/politeness at interview.
5. Personal appearance of the candidate.
6. Performance on ethical questions at interview.
7. Letters of recommendation by an orthopedic surgeon.
8. Candidate is an Alpha Omega Alpha (AΩA) Academic Society member.
9. Medical school reputation.
10. Dean's letter.

Ranked 11th in order on the same list was the personal statement. Returning to the question of advantage and privilege, one has to wonder about the competitiveness of a minority orthopedic residency applicant who completes his or her medical school education at a majority medical institution. In order to develop a competitive résumé, women and under-represented minorities must immediately excel academically and achieve a high GPA (ranking in the upper 10% of their class) and gain admission to the AΩA Honor Society. Women and under-represented minorities must receive early mentoring, preferably at the end of medical school year one (the first of the two-year basic science preclinical years), in order to develop an effective strategy for dossier or curriculum vitae development, which would include a letter of recommendation by an orthopedic surgeon, a telephone call from a mentor (preferably an orthopedic surgeon) to members of the Orthopedic Education Committee or Residency Admissions Committee. In addition, women and under-represented minorities must also produce a list of publications relevant to the orthopedic surgical subspecialty. Reliable mentoring that would allow women and under-repre-

sented minorities to achieve these early goals is especially difficult to obtain, especially since women and minorities are often ignored or marginalized during the critical third- and fourth-year clerkships (critical rotations in surgical subspecialties, e.g., orthopedics, urology, ENT, plastic surgery, neurosurgery, transplant surgery, cardiovascular surgery, and vascular surgery.)

Other obstacles for early curriculum vitae development includes a dearth of same-gender and/or same-ethnic-group mentors and role models available to the minority candidates seeking information, seeking guidance, and seeking research opportunities that might lead to publication.

Further, the criteria of "formality/politeness at the interview" and "personal appearance of the candidate" are undeniably subjective. When the interviewer is a white male, then these criteria are judged by white-male standards (even if the interviewer bears no overt prejudice in his heart). The interviewer (more often than not) views the ideal candidate as resembling himself. This puts women and minorities at a disadvantage, since other candidates who do resemble the interviewer and exhibit culturally bound kin characteristics are given preferment: one more part of the puzzle completed for them without any merit on their part.

One of the popular myths conveyed to women and under-represented minorities continues to include the tracking or channeling toward nonsurgical specialties, such as internal medicine, pediatrics, or primary care. Even if the medical student is able to see beyond this popular myth, there is always the old standby of "why bother to apply." Many orthopedic programs in the United States have yet to be integrated by women or under-represented minorities, and there are many orthopedic residency programs in the United States that have no serious plans to change their traditions of their preferred male-dominated country club cultures.

Item Number 11, "Personal Statement" listed by Bernstein et al., would receive a very high ranking within a minority-dominant orthopedic residency education program, such as Howard University Hospital or the King Drew Orthopedic Residency Program in Los Angeles, CA. A review of the personal statement by the Orthopedic Education Committee allows the evaluators a greater chance to understand the perspective of the individual's accomplishments. Candidates may not have achieved Alpha Omega Alpha Honor Society status, but they might alternatively exhibit focus, maturity, desire, drive, hunger for accomplishment, and singleness of purpose. These attributes may be indicative of what has often been termed "distance traveled." What we mean by the distance traveled is the overcoming of social and economic obstacles. Examples of distance traveled might include excellent and highly competitive sports activity, suggesting desirable character traits: reliability, diligence, the ability to work with a team, commitment, respect, interpersonal skills, and family support and encouragement. Another example might be consistent academic achievement in spite of obvious economic disadvantages or diminished parental contribution due to lack of economic resources or educational sophistication. Sometimes, the personal stories of these individuals are indicative of great personal achievement that is not measured by conventional devices. This is because traditional measures (for the most part) take as their model individuals who are handed a puzzle 80% completed. If this is the model, then all measurements are based upon gradations within that range. Achievements outside that range are not measured. They are often seen as irrelevant "noise."

Bernstein et al.'s *JB&JS* article points out that program directors considering new applicants are favorably impressed by: 1) letters of recommendation written by "someone I know," 2) personal statements that list the candidate's personal interests and background, and 3) an interview process that places "an emphasis on getting to know the applicant." These should be seen in the context of the 80% completed puzzle-maker. The present system tends to support a continuing clique of the advantaged. If recognition of distance-traveled deserts were factored into the picture, this assessment process would change toward a fairer, more ethical procedure. As a final note, one should consider that "50–75% of the candidates who are offered interviews are AΩA

**Figure 2. The Professional Social Contract**

1. All professions entail the existence of an implied social contract—Assertion
2. All professional social contracts are between the host society and the individual profession—Fact
3. Society (in this context) is understood as a set containing various subsets of sociologically distinct populations—Assertion
4. What is true of the whole is also true of each subset (re: the social contract)—Assertion
5. Each distinct sociological population has a contract with each profession—1–4
6. Part of any social contract is the expectation that the profession (or any other institution) will be responsive to its needs—A
7. The best way to insure responsiveness and need inclusion is via proportional professional representation—A
8. Each distinct sociological group should have proportional professional representation—5–7
9. Lack of proportional professional representation constitutes a breech of the professional contract by the profession—2, 5, 8

members." In the year 2000, there were 1,116 applicants for 554 year-one (postgraduate year one) orthopedic residency positions. This means that the competition is intense and that the selection criteria themselves favor those with traditional credential files (the 80-percenters).

If we are correct in our puzzle-maker thought experiment, then many turned down from college/medical school/residency programs (because someone else is farther along on the puzzle) are more deserving than others who are admitted. If merit is measured by what the individual accomplished by him or herself, then it may often be the case that we are admitting those with less merit (but possessing preferment) over those of greater merit (without preferment). It is very probable that the person who most deserves to become the surgeon is person Ms. A (the one who has traveled the greater distance) because she has accomplished so much already in her life. We should all feel more comfortable training her to hold the scalpel because she's already proven herself to be the more deserving.

## The Professional Ethics Argument for Proportional Diversity

So far this essay has contended that morality demands proportional diversity in the professions (based upon the puzzle-maker model of merit). This section will also argue for the ethical foundations of proportional diversity within the professions via an argument that goes to the nature of professional ethics itself: the contract with the host society. On a general level, professions can be said to operate because of a contract with the society. One version of this contract can be seen in Figure 2.

Obviously, the most controversial premise in this argument is premise #7. It is incumbent upon those making this sort of case to show that the when the social contract is breeched it results in a failure to fulfill premise #6, e.g., in a reduced access to care in the affected population and in less cultural competence within the profession. In order to address these and other issues surrounding premise #7, it is necessary to provide further information on the social contract itself.

The profession has specialized knowledge that can be delivered in a reliable fashion, and this knowledge can benefit society. From the professional's point of view, this relation entails certain rights and responsibilities. The rights are that the profession may govern itself (so long as it is responsible). This means that the profession has crucial input in terms of selection, education, and practice. The responsibilities involve being responsive to the society at large that enfranchises the profession. In turn, society has certain rights and responsibilities. The rights include expectations of professional excellence in education and practice. They also include fulfilling the social contract to meet particular social needs for the entire society—not merely some advantaged subgroups of the society.

The responsibilities of society include treating professionals as people. This means that they must be given respect, support, and compassion in the exercise of their professional duties.

However, as the argument in Figure 2 points out (premise #7), the social contract requires proportional representation in order for the profession to fulfill its responsibilities to society. It would seem that those sociological groups who are under-represented among orthopedic surgeons are not having their contractual rights upheld. This is because when the profession is proportionally skewed away from particular groups, the social contract has been abrogated (conclusion of the argument in Figure 2). The profession that is not proportionally diverse is in material breech of the social contract. Such a breech must be rectified on the basis of the professional contract between the profession and society. So long as the professional contract is an ethical one, the weight of ethical duty attends to rectifying this imbalance.

Thus, the very fact that some groups are severely under-represented in a profession (for example African Americans are 12% of the general population in the United States and yet they are only 6% of the population in medical school; 5% of medical school graduates are African-American; and 3% of medical doctors in practice are African-American while 2% of the medical school faculty are African-American). These statistics are significant. While 6% of the admitted medical school students are African-American, this figure shrinks to 2% of the faculty being African-American. There is no getting around the fact that African Americans are not proportionately represented in medicine. Through exclusionary practices (intended or not), there is no proportional representation and the social contract between medicine and the African-American population (a subset of the American society) has been breeched.

One can only conclude two things from the statistics showing proportional disparities: (a) either African Americans are not suited for such "high-powered intellectual activity" or (b) the medical school community worldview is constructed in such a way that it disadvantages African Americans. Two pieces of evidence for the latter view are: 1) The representation of African Americans in medical school is around 50% of their societal numbers. This compares with South Africa (long a society ravaged by cruel apartheid). In South Africa, blacks in medical school are around 30% of their societal numbers. 2) AΩA membership (already established as an important factor in being accepted for a prestigious resi-

dency) has only 1.3% African-American members and 26% female members. If the medical profession in general and orthopedic surgery in particular were really open to diversity, these numbers would be different. For this reason alone, the profession of orthopedic surgery in the United States is in material breech of its professional contract with the American people. It must therefore take immediate steps to rectify this situation. (See Section Three.)

In Section One of this essay, it has been argued that there is a general ethical duty to promote diversity in the professions based upon a view of merit depicted in the puzzle-maker model. In addition to the moral duty, a professional duty for diversity was put forth based upon a notion of a professional social contract.

## SECTION TWO: THE PRUDENTIAL ARGUMENT FOR PROFESSIONAL DIVERSITY

At this point, our argument takes a rather different direction. We contend that (ethics aside) a profession that is more diverse in its membership will be more excellent in the execution of its functional tasks than one that is not diverse. For purposes of clarification, we will term functional excellence, the prudential argument. Our prudential argument has two parts: a) the matching argument, and b) the social evolution argument. These will be addressed in order.

### The Matching Argument

It is generally agreed that the functional practice of medicine requires sympathy (sometimes called empathy) and care. These terms are understood as indicating both an emotional and an intellectual connection with the patient. Thus, a physician who cannot connect with her or his patient on an emotional and intellectual level in the sense of understanding the patient via both dimensions will be a functionally deficient practitioner. For example, if a physician fails to recognize ways that a patient emotively communicates to her, then she will be minus key facts about her patient. These key facts may be crucial in creating a diagnosis. Without them the physician is more prone to error. Making a wrong diagnosis is to be functionally deficient in the art and science of medicine. Thus, the physician who does not connect emotively with her patient puts herself in the position of rendering a deficient diagnosis (and all that follows from this: prognosis, treatment, etc.). Such a physician is functionally inferior to another physician who *can* connect with that patient.

The same holds true with intellectual communication. Since much of rational human communication is in enthymemes, the physician is forced to fill in the gaps. But sometimes the enthymemes require cultural literacy and some common connectedness that may go beyond just being a fellow human-being living in the world. For example, some Latinas from Central America believe that breast cancer comes about as the result of loose living and so are reluctant to proceed with treatment even when a lump is detected. If the attending physician is not Latino/Latina or culturally competent in Central American culture, then he or she is liable to be ineffective as a provider of care. Likewise, an African-American physician who has sympathy/connection with black urban poor may better be able to communicate and render a professionally more accurate diagnosis so that the proper treatment might be undertaken.

Again, in another example (from The Holms Society), a 45-year-old African-American male with chronic back pain had an L4-5 laminectomy and fusion and still complains of significant pain. The patient is using low doses of codeine on a daily basis. You prescribed 25 mg of amitriptyline for the patient to take at bedtime and instructed the patient to increase to 50 mg after five days. The patient returns one month after you initiated the amitriptyline. He has not been taking it every night because he could not tolerate the side-effects. What is the next best step? This case involves knowledge of the physiology of African Americans. Since African Americans attain higher blood levels than whites when taking identical doses of tricyclics, the dose prescribed should take that into account—otherwise toxic side-effects may result. It is more likely that an African-American physician will be more sensitive to the physiology of his black patients than a white doctor and, thus, make a prescription for the appropriate dose of medication. This is another instance in which having a proportional diversity of physicians can increase professional excellence.

Now, in principle, anyone sensitized to these crucial cues would be able to offer a professional level of care to the patient. However, such connectedness is difficult to come by. It is not taught in most medical schools—and is best possessed by people of similar racial/gender/ethnic backgrounds. What the authors see as the optimal solution to this problem is that the professions (here, orthopedic surgeons) possess proportional demographic representation. If this were the case, then these individuals would be there to help train the rest of their colleagues on the fine points of cultural literacy (necessary for proper communication between patient and doctor). They would be there—both to care directly, to consult with the direct caregiver, and to discuss common problems in clinical settings. If there were proportional representation in the field, and if these physicians were evenly distributed around the country (at least consistent with that population's relative concentrations), then according to the preceding argu-

ments, the African-American patients would receive better care and the functional practice of orthopedic medicine would be practiced at a higher level. (The same, obviously, holds true for other under-represented groups, such as Latino physicians, Native American physicians, and women physicians.)

Thus, since the demographics of the United States are heterogeneous with (for example) African Americans constituting 12% of the population, and since it has been argued that subpopulations are best served by there being a proportional diversity in the professional caregivers, it would seem logical that orthopedic surgeons (as well as all other professions) would become functionally more excellent by taking active steps to insure proportional diversity (see the last section of this essay for an outline of these steps).

## The Social Evolution Argument

Evolutionary theory in biology has proven to be a very useful theory. It has wide explanatory power and has acted to unite the field of biology. In fact, evolutionary theory has been so successful that beginning with the sociobiologists led by E.O. Wilson and Richard Dawkins, they have moved evolutionary biology into the social realm. This has led to a bifurcation between those such as Wilson and Dawkins, who want to assert that there is a biological basis to all behavior (biological determinism) and others, such as Eliot Sober and Richard Sloan Wilson, who wish to adapt biological theories into sociological models (though both are philosophers of biology). If one were to adapt models of biological evolution onto the social realm, then the same postulates that rule biology would apply to human society. The postulates that interest us are:

- There is racial/ethnic variation in a society (such as the United States)
- The environment of the United States (the intrastructure and the exostructure) is constantly in flux
- Populations that are robustly diverse will be survive changing environments better than those that are not
- Countries that do not empower their diverse populations are virtually the same as homogeneous populations

From these four principles, we can infer that homogeneous populations and those that are virtually the same as homogeneous populations, viz., those that do not empower their diverse subpopulations, will be functionally less fit for performing excellently in a diverse world. This is because each subpopulation can be described by a set of character traits. No trait is good or bad by itself but merely effective or not within a certain environment. For example, if there were a robust population that was heterogeneous and within the population there were individuals who were excellent at tracking several problems at the same time and quickly moving their attention from one task to the next, then these individuals (in an "information age" environment 1) will help the population succeed. In this event, the existence of quick-thinking, phrenetic individuals will be prized within the population.

However, if we take these same individuals and pattern a new technological society (environment 2) in which quick decisions cease to be important but slow-thinking pondering of a single problem is the critical factor for success, then the population will need some slow-thinking individuals who can stay on a single problem for extended periods of time. The phrenetic individuals so prized in environment 1 will become losers in environment 2.

So is it "better" to be quick-thinking or to be slow thinking? The answer is that neither are per se better but only relatively better given certain environmental factors. This is why the most successful populations are those that will be the most diverse and welcome, honor, and support this diversity.

Yet, when we look at the reality of life in America (or virtually any other country we've heard of), it seems that the aim of public policy is to only allow diversity if it means to bring in more janitors, farm workers, or other underpaid "semislaves." This servitude mentality is meant to preserve preference against the model of merit (discussed earlier). Under the model of social evolution, this is a prescription for social disintegration. Since it's a given that social environments (as well as biomes) will change, unless the population has groomed a representative cross-section of its population to carry on its professions, these professions (arguably the backbone of society) may (probably) functionally degenerate under these new conditions, and the society will suffer.

If this argument is correct, then all significant groups in the society must be represented within the professions. In the case study of this essay (African-American representation in orthopedic surgery), this means that for the functional good of the profession, drastic measures must be taken now. Otherwise, the future of the profession is doomed to unresponsive, decadent decline.

## SECTION THREE: MODES OF IMPLEMENTATION

This essay has examined diversity rights claims within the medical profession systemically—especially in its manner of training and admitting new practitioners to orthopedic surgery. If the above argument is correct, increasing diversity among African Americans, Latinos, Native Americans, and

women in orthopedic surgery is necessary for moral and prudential reasons. In order to effect this vision, the following are a few first-steps that may bring us closer to this goal.

- Change in the shared community worldview that describes the model for an orthopedic surgeon. The model needs to be broadened to include a diverse set of people (gender and races). Professionals within the community must be able to "picture" minority individuals as being represented proportionally within the profession.

- Include "distance traveled" considerations for admission to medical school and especially for admission to prestigious residency programs (such as orthopedic surgery). Those who have completed much of the puzzle should be given credit for such.

- Take immediate actions to create situations of mentoring that proactively seek out minorities and women in their first year of medical school so that they might feel welcomed to explore all the areas of medicine and that their talents and personal worldviews might incline them. This includes advice on early planning so that they might create their strongest résumé.

- Create workshops with faculty so that they might devise and obtain ownership for specific initiatives directed at self-study of the current program with the goal in mind that all programs in medicine be made available to all students in a real way—through offering development sessions and ensuring that all students are counseled in a nurturing way.

These suggestions are first steps. These are not measures aimed at holding anyone's hand. They are rights that medical students deserve—especially those who have come a long way to get there. The medical profession has a contract with society to produce excellent physicians that can meet the needs of society as a whole. A lack of diversity means a functional gap in excellence. Greater diversity that matches the demographics of the society will enhance the performance of professional practice.

The medical community should also operate according to moral criteria. Obviously, problems of societal racism and sexism cannot single-handedly be solved in any one arena. But that should not be used as an excuse for inaction. A fundamental effort toward democratic opportunity is needed now—not in a legalistic fashion but in the spirit of authentic good will that, on the one hand fulfills society's moral duty, while on the other makes the medical community itself a more efficient and excellent purveyor of beneficence and nonmalfeasance. The orthopedic surgeons of America should demand nothing less!

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3. The reader should note that 'merit' (often referred to in the literature of philosophy as 'deserts') refers to a theory of what agents can justifiably claim on the basis of their achievements.

4. By 'puzzle-maker' we mean the person who puts a puzzle together, not one who manufacturers it.

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12. The reason that professionals deserve respect, support, and compassion is that they are fallible humans and not gods. So long as the professional upholds her or his side of the contract, then it seems reasonable for society to do so, too. For more on this see Boylan M, Donahue JA. Ethics across the curriculum Lanham, Boulder, Oxford: Lexington Books; 2003: chapter 5.

13. An example of an unethical contract would be certain social contracts between criminal associations (such as the Mafia) and a group of people. "We will protect you so long as you pay us protection money [extortion]." However, the example given above is far from this sort of exception.

14. JAMA. 1989;261.2.

15. Price M, Smuts B. Prospective students and parents: attitudes toward a graduate-entry medical degree. *South African Medical Journal*. 2002; 92.8: 632-633.

16. Babbott D, Weaver SO, Baldwin DC Jr. Personal characteristics, career plans, and specialty choices of medical students elected to alpha omega alpha. *Archiv Intern Med*. 1989;149:586-580.

17. Some would seek to separate 'empathy' from 'sympathy.' 'Empathy' is a word that (according to the Oxford English Dictionary) entered the language in 1912 as a translation of *ein* (in) + *fühlung* (feeling) into English after the writings of Lipps H, Academy. The Monthly Record of Literature, Learning, Science, and Art. 1912; 17: 209. Lipps set forth a theory of literary criticism based upon one's ability to project himself into the work of art. This is similar in content to Keats's "negative capability." For a discussion on the historical development of this term in English see: Wispé LG. The history of the concept of empathy. In: Eisenberg N, Strayer J eds. Empathy and its development. NY: Cambridge University Press; 1987:17-37. (Wispé puts the date into English at 1909.) Many try to draw distinctions between 'empathy' and 'sympathy' with the former indicating the connection of feeling and the latter a connection that is attached with a sorrow for another's

plight. For some discussion of this point of view see the collection of essays, in Eisenberg and Strayer (1987). Since 'sympathy' means in Ancient Greek *sym + pathos* (a connection of feelings), this seems to be sufficiently robust for our argument. 'Care' is the action response to 'sympathy' for an extended discussion of these relations, see: Boylan M, A just society. Lanham, Boulder, Oxford: Rowman and Littlefield; 2004 ; chapter 3.

18. Chavez LR, Hubbell FA, McMullin JM, et al. Understanding knowledge and attitudes about breast cancer: a cultural analysis. *Arch. Family Medicine.* 1995;4:145-152 and Morgan C, Park E, Cortes DE. Beliefs, knowledge, and behavior about cancer among urban hispanic women. Journal of the National Cancer Institute Monographs. 1995;18:57-63. Part of the problem may also be related to minority women's health. Recent studies of note that discuss cultural problems in treating Hispanic women who have had medical problems are discussed in: McCartney P. Internet resources on minority women's health. MCN, *American Journal of Maternal Child Nursing.* 2002; 27: 355 and Riegel B, Cailson B, Glase D, et al. Standardized telephonic case management in a hispanic heart failure population: an effective intervention. *Disease Management and Health Outcomes.* 2002;10: 241-249.

19. The exploration of multicultural literacy in clinical practice is a developing area of research. Recent work includes: Kundhal KK. Cultural diversity: an evolving challenge to physician-patient communication. *JAMA.* 2003; 289:94; Tanne JH. U.S. medical schools should consider race in admitting students. *BMJ.* 2002;325:565; Tolo V. The challenges of change: is orthopaedics ready? *JB&JS.* 2002; 84: 1707-1713; the special theme issue of Academic Medicine 77.3 (2002)—especially Fuller K. Eradicating essentialism from cultural competency education; and Green AR, Betancourt JR, Carrilo JE. Integrating social factors into cross-cultural medical education, and Drouin J, Jean P. Educating future physicians for a minority population: a french-language stream at the university of Ottawa, and Hunt LM, Beyond cultural competence. *The Park Ridge Center Bulletin.* November/December, 2001:3-4, and McCurdy DB. A 'competence' we can't do without.' *The Park Ridge Center Bulletin.* November/December, 2001:2, and Barnes L, Harris G. Changing medical landscape. *The Park Ridge Center Bulletin.* November/December, 2001:7-8. See also: Nuñez AE. Transforming cultural competence into cross-cultural efficacy in women's health education. *Acad Med.* 2000;75:1071-1080; Brach C, Fraser I. Can cultural competency reduce racial and ethnic health disparities? *Med Care Res Rev.* 2000;57(suppl. 1):181-217; Mayberry RM, Mili F, Ofili E. Racial and ethnic differences in access to medical care. *Med Care Res Rev.* 2000;57(suppl. 1): 108-145; Carillo JE, Green AR, Betancourt JR. Cross-cultural primary care: a patient-based approach. *Annal Intern Med.* 1999;130:829-834; Lantz PM, House JS, Lepkowski JM, et al. Socioeconomic factor, health behaviors, and mortality: results from a nationally representative prospective study of U.S. adults. *JAMA.* 1998;279:1703-08; and Culhane-Pera KA, Reif C, Egli E, et al. A curriculum for multicultural education in family practice. Family Medicine.1997;28:719-723; Boylan M, Culture and medical intervention. *Journal of Clinical Ethics.* forthcoming, 2004.

20. Compare to Kundhal KK. Cultural diversity: an evolving challenge to physician-patient communication. *JAMA.* 2003;289:94; Grady D. Not a simple case of health racism. *New York Times.* November 17, 1999; Cooper-Patrick L, Gallo JJ, Gonzales JJ, et al. Race, gender, and partnership in the patient-physician relationship. *JAMA.* 1999; 282:583-589.

21. The model of E.O. Wilson is one of group selection while Dawkins offers an individual selection model. Between these are the kin selection accounts. For group selectionists see: Wilson EO. Sociolobiology: the new synthesis. Cambridge, MA: Harvard University Press; 1975 and Bossert WH, Wilson EO. A primer in population biology. Stanford, CT: Sinauer Associates; 1971. For an exposition of the selfish gene theory see: Dawkins R. The selfish gene. NY: Oxford University Press; 1976, 2nd ed 1989, and The extended phenotype: the long reach of the gene. NY: Oxford University Press; 1982. For an exposition on kin selection see: Smith JM. Group selection and kin selection. *Nature.* 1964;201:1145-1146 and How to model evolution. in Dupré J, ed. The latest and the best: essays on evolution and optimality. Cambridge, MA: MIT Press; 1987:119-131.

22. Sober E, Wilson DS. Unto others: the evolution and psychology of unselfish behavior. Cambridge, MA: Harvard University Press; 1998.

23. One variant upon this argument is the position that "race" is not a robust social or biological classification. The authors of this essay tend toward this direction with the caveat that among most of American society this is certainly not the case. For this reason, we will assume the existence of race for practical purposes. However, in reality, homo sapiens is the only robust category for a species (under the traditional definition: capable of inter-reproduction). Other accidental differences exist for the artificial purpose of subjugating another for selfish purposes.

24. By "intrastructure" it is meant the social landscape of what it means to exist in America during the present age. For example, the rise of computer applications during the 1990s made a big difference in the intra-structure of the United States. Those plugged into the information economy profited mightily. Those without these resources became poorer. By "exo-structure" it is meant the social landscape of what it means for America to exist in the world. When the communist Soviet Union fell in the late 1980s the international climate changed radically. The same might be said about the terrorist attack of 9/11/01 in New York and Washington, DC.

25. This point is often argued from different vantage points. For a range of these see: Sloan and Wilson, op cit., Owen DS. Habermas's developmental logic thesis: universal or eurocentric? *Philosophy Today.* 1998;42 supp.:104-161; Strydom P. Sociological evolution or social evolution of practical reason: Eder's critique of Habermas. *Praxis International.* 1993;13:304-322; Fara P, Gathercole P, Laskey R. The changing world. Cambridge: Cambridge University Press; 1996.

26. Others who have made similar claims include: Rogers C. Leading the way: mentors help minorities cross barriers to careers. *AAOS Bulletin.* 1999:43-44; Miller RS, Dunn MR, Richter T. Graduate medical education: 1998-1999. JAMA. 1999;282:855-860; Simon MA. Racial, ethnic, and gender diversity and the resident operative experience. *Clin Orthop.* 1999;360: 253-259. ■

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