

Diversity and Academic Accomplishments for Presidents Elected to Domestic and International Hip and Knee Adult Reconstruction Societies

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ABSTRACT

Introduction: Over the past two decades, orthopaedic subspecialty leadership has had increased scrutiny for its lack of diversity and transparency, particularly within adult reconstruction societies such as the Hip Society, Knee Society, AAHKS, the European Hip Society, International Hip Society and the British Hip Society. Academic accomplishments and demographics for Presidents of hip and knee arthroplasty societies remain poorly understood. This study seeks to characterize the demographic evolution of leaders in adult reconstruction societies using publicly available information to assess changes in age, sex, race/ethnicity, and training background.

Methods: We conducted a retrospective cross-sectional review of orthopedic leadership demographics across six major arthroplasty societies from 2017-2026: The Hip Society, The Knee Society, American Association of Hip and Knee Surgeons (AAHKS), European Knee Society, International Hip Society, and British Hip Society. For every identified leader, we collected key demographic and educational variables. The primary data points included: age at appointment to leadership position, sex, race, number of years leadership position was held, arthroplasty fellowship training, location, private or academic practice, and any additional degrees or fellowship training completed. Data was obtained from each of the society archives and websites, as well as missing data supplemented through directories and verified professional biographies found on the publicly accessible sources.

Results: There were 53 arthroplasty presidents across the six major societies analyzed. Most presidents were male (98.1%) and Caucasian (90.57%). There was one female president (1.88%) and five non-Caucasian presidents (9.43%), including one Asian president (1.88%) and one Persian/Iranian president (1.88%), two Indian president (3.77%), and one Lebanese president (1.88%). There were no significant differences in demographics between the six arthroplasty organizations and the two time periods ($P > .05$). The most common fellowship programs of Society Presidents were Massachusetts General Hospital (13.2%), Hospital for Special Surgery (11.3%), Mayo Clinic - Rochester (11.3%), and Rush (7.5%).

Conclusion: While there is diversity of experiences in Adult Reconstruction society presidents, there are still opportunities to promote gender, as well as racial and ethnic diversity amongst leaders in this subspecialty.

Keywords: Diversity, Orthopedic Leadership, Academic Accomplishments, Surgical Societies, Adult Reconstruction

Introduction

Despite strides made to improve diversity, orthopaedic surgery remains the least diverse specialty in medicine [1,2]. According

to the American Academy of Orthopaedic Surgeons (AAOS) membership, 85% of its members are White, while Hispanic and Latino members represent only 2.2% of practicing orthopaedic surgeons, and Black individuals account for just 1.9% [1]. Furthermore, underrepresented applicants face lower odds of matching into the specialty, and trainees experience

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disproportionately elevated rates of residency attrition [1,3]. While the overall minority and female representation across residency programs averages roughly 25% and 14.4% respectively, this pipeline narrows severely based on various subspecialties [1]. Pediatric orthopaedics and musculoskeletal oncology consistently attract the highest proportions of female and minority trainees, while adult reconstruction continues to lag behind [4]. Recent 14-year Accreditation Council for Graduate Medical Education (ACGME) data reveals that Black and Hispanic surgeons constitute only 3% and 4% of adult reconstruction fellows, respectively, with women comprising merely 5.7% [4,5].

The lack of diversity is also seen amongst Fellowship-Trained Adult Reconstruction surgeons as well as within leadership positions within Adult Reconstruction societies. With the increasing competitive nature of matching into an Adult Reconstruction fellowship, selection is frequently dictated by relationship-dependent variables, such as subspecialty-faculty sponsorship, subjective interviews, and institutional prestige [2,6]. Recent literature highlights the effect of internal mentorship networks, demonstrating that orthopaedic residents are significantly more likely to match into arthroplasty if their residency program director is arthroplasty-trained [6]. Previous studies have examined the characteristics of presidents nominated to serve in the Knee Society, Hip Society and American Academy of Hip and Knee Surgeons. This study seeks to expand our understanding of the demographic factors, training pathways, academic accomplishments of individuals elected president of prominent domestic and international hip and knee adult reconstruction societies from 2017 to 2026.

Methods

Study Design

We conducted a retrospective cross-sectional study of presidential leadership within six major professional societies focused on adult hip and knee reconstruction. The societies included are The Hip Society, The Knee Society, American Association of Hip and Knee Surgeons (AAHKS), European Knee Society, International Hip Society, and British Hip Society. These organizations were selected on the basis of their national and international prominence and their defining role in shaping clinical standards, research priorities, and professional culture within adult reconstruction surgery. Presidential appointments from 2017 through 2026 were identified using publicly available society records and leadership archives. Each presidential appointment during the study period was included in the analytic cohort.

Data Collection

Current and former presidents were identified primarily through official society websites, historical leadership archives, and published presidential rosters. For each individual, publicly available sources were reviewed to collect demographic, educational, and professional characteristics. When information was not available through society records, data was supplemented using institutional faculty profiles, professional biographies, publicly available curricula vitae, physician directories, training program records, and other verifiable professional sources. Variables collected included age at presidential appointment, sex, race and ethnicity, duration of presidential service, orthopedic

surgery residency training, fellowship training, fellowship institution, completion of an adult reconstruction or arthroplasty fellowship, additional fellowship training, advanced academic or professional degrees, geographic location of practice, and practice setting. Practice setting was categorized as academic or private practice according to the individual's primary professional affiliation at the time of presidential service.

Fellowship training was reviewed to determine whether each president had completed formal fellowship training in adult reconstruction, hip and knee arthroplasty, or another orthopedic subspecialty. Fellowship institutions were recorded individually to characterize the distribution of training programs represented among society presidents. Additional fellowship experiences, including nonarthroplasty clinical fellowships and research fellowships, were also recorded when documented. Fellowship programs were summarized by institutions to determine if the trends in Presidential Leadership were represented by graduates of particular training centers. Additional academic or professional degrees beyond the primary medical degree were recorded when available.

Race and ethnicity were determined through a combination of self-reported information found in publicly accessible biographies, surname analysis consistent with validated methodologies used in prior orthopaedic workforce studies, and photographic identification where corroborated by supplementary sources. When race or ethnicity could not be determined with reasonable confidence through these means, the individual was classified as indeterminate and excluded from racial and ethnic subgroup analyses.

Study Outcomes

The primary outcomes were the demographic characteristics of society presidents, including sex, race or ethnicity, and age at presidential appointment. Demographic representation was evaluated overall, across societies, and between the 2004 to 2015 and 2016 to 2026 study periods. Secondary outcomes included years from residency completion to presidential appointment, completion of adult reconstruction fellowship training, fellowship institution, additional fellowship training, advanced degrees, practice setting, geographic location, and duration of presidential service. Fellowship institutions were additionally evaluated to identify training programs that were most frequently represented among society presidents.

Statistical Analysis

Descriptive statistics were used to characterize demographic, educational, and professional characteristics of the study population. Categorical variables were reported as frequencies and percentages. Continuous variables, including age at presidential appointment and years from residency completion to appointment, were summarized using means and standard deviations when appropriate.

Demographic characteristics were compared across the six societies and between the 2017 to 2026 period. Given the small number of women and individuals from racial or ethnic minority groups within the cohort, categorical comparisons with sparse expected cell counts were evaluated using Fisher exact testing rather than relying exclusively on Pearson chi-square testing.

Continuous variables were compared between two groups using independent-samples t tests when distributional assumptions were appropriate, with comparisons across more than two societies performed using analysis of variance as applicable. All statistical tests were two-sided, and statistical significance was defined as $P < .05$.

Results

There were 53 arthroplasty presidents across the six major societies analyzed. Most presidents were male 52 (98.1%) and Caucasian 48 (90.57%). There were 1 woman (1.88%) and 5 non-Caucasian presidents (9.43%), including 1 Asian (1.88%) and 1 Persian/Iranian (1.88%), 2 Indian (3.77%), and 1 Lebanese (1.88%). There were no significant differences in demographics between the six arthroplasty organizations ($p > .05$). The most common fellowship programs of Society Presidents were Massachusetts General Hospital (13.2%), Hospital for Special Surgery (11.3%), Mayo Clinic - Rochester (11.3%), and Rush (7.5%). The majority of presidents across the six societies practice in academic medical centers (66.04%), versus private practice (33.96%).

Fellowship training was common across all three societies and was predominantly completed at established U.S. arthroplasty centers. AAHKS presidents demonstrated the greatest variety of fellowship training locations, however Massachusetts General Hospital/Harvard, Hospital for Special Surgery, Mayo Clinic and Rush, Mayo Clinic, were most commonly represented. Although most Hip Society presidents had completed arthroplasty or adult reconstruction training, several demonstrated alternative or additional fellowship pathways, such as hand/reconstructive surgery, hand and upper-extremity surgery. Overall, fellowship training patterns suggest that leadership within these societies has remained concentrated among graduates of a relatively small number of highly established arthroplasty and reconstruction training programs.

Conclusion

Analysis of the leadership in the Hip Society, Knee Society, and American Association of Hip and Knee Surgeons (AAHKS), International Hip Society and British Hip Society remained demographically consistent throughout periods approximately around 2017–2026. In a cross-sectional study by Silvestre et al, of 97 presidential appointments representing 78 unique leaders from 1990–2022, presidents assumed office at a mean age of 55 ± 10 years, approximately 24 years after residency; 99% were male, 1% female, 95% White, 2% Asian, and 3% Hispanic, with no Black presidents identified [7]. Although 68% of presidents completed adult-reconstruction fellowship training, leadership pathways were concentrated within influential institutions mainly Hospital for Special Surgery (21%) and Massachusetts General Hospital (8%) [7]. This information suggests that institutional prestige, mentorship, professional networks, and scholarly opportunity may influence advancement. Presidents also demonstrated substantial academic productivity, with a median h-index of 53 and 191 publications, although only 2% had received NIH funding. In summation, adult-reconstruction leadership through 2022 was characterized by experienced, academically productive, predominantly White male surgeons trained disproportionately at a limited group of fellowship centers [8].

Future investigations should expand the range of Presidential leadership to include the past 20 years and examine leadership pathways to include committee membership, board service, awards, speaking opportunities, fellowship directorship, nominations, and presidential selection. These pathways may aid in determining the other factors that help promote Adult Reconstruction surgeons to Presidential leadership. Prospective studies using self-reported race, ethnicity, sex, gender identity, socioeconomic background, disability status, and fellowship location should evaluate whether transparent nomination criteria, leadership development, longitudinal mentorship, active sponsorship, and wider geographic recruitment improve advancement. It is important to note that the current evidence is limited by its retrospective cross-sectional design, limited number of presidents, reliance on websites and curricula vitae, possible misclassification of race and sex, broad racial categories, and inability to establish causation.

Presidential appointments also reflect achievements and networks accumulated over decades, creating a substantial lag between diversification of trainees and changes in senior leadership, while institutional concentration may represent self-selection or academic productivity rather than preferential selection. Furthermore, the lack of diversity in society leadership underscores the need to continue to create pipelines that will overall diversify the specialty of Orthopaedic surgery. Nevertheless, ways to broaden diversification within orthopaedics leadership should include deliberate expansion of society membership, equitable access to fellowships and high-visibility assignments, formal sponsorship of women and underrepresented surgeons, and continued longitudinal reporting of leadership demographics [9,10].

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