

## **Remembering George Floyd**

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George Floyd grew up in Houston, Texas, in the Third Ward, a historic Black neighborhood. He played football and basketball at Jack Yates High School, where he helped lead his football team to the state championship game in 1992. He then continued sports at South Florida State College before transferring to Texas A&M University - Kingsville. His college basketball coach started him as a power forward and he later remembered Mr. Floyd's athleticism and how he consistently contributed 12 to 14 points and 7 to 8 rebounds in a game (Fernandez and Burch). Returning home without a degree, Mr. Floyd began a hip-hop career as Big Floyd in the mid-1990s with two groups, Screwed Up Click and later, Presidential Playas. An article in the New York Times described some of the challenges Mr. Floyd faced during this period as a young Black man in Houston: "At times, life in the Bricks was unforgiving. Poverty, drugs, gangs and violence scarred many Third Ward families. Several of Mr. Floyd's classmates did not live past their 20s...For about a decade starting in his early 20s, Mr. Floyd had a string of arrests in Houston, according to court and police records. One of those arrests, for a \$10 drug deal in 2004, cost him 10 months in a state jail" (Fernandez and Burch). The officer whose sole testimony led to that conviction in 2004 was later investigated for falsifying evidence, leading the Harris County District Attorney, Kim Ogg, to request a posthumous pardon for Mr. Floyd (Barker). In later years, through his church and other community organizations, Mr. Floyd mentored young men and shared his own experiences and mistakes. He also advocated against violence on social media, delivered meals to senior citizens and nursed his mother after her

stroke (Kantor). In 2014, Mr. Floyd moved to Minneapolis for a fresh start. Like many Americans, he lost his job in security due to the COVID-19 pandemic in early 2020 (Rao). On May 25, 2020 a store clerk alleged that Mr. Floyd passed a counterfeit \$20 bill and called the police. And then, seventeen-year-old Darnella Frazier captured a video that would no longer allow non-Black Americans to turn a blind eye to police brutality and structural racism in Black communities. Many around the world watched, from a Black teenage girl's viewpoint, former Minneapolis police officer and now convicted murderer, Derek Chauvin, kneel on Mr. Floyd's neck for 9 minutes and 29 seconds while Mr. Floyd pleaded for help and for his mother. Personal friend and NBA star, Stephen Jackson, told the New York Times, "I tell people all the time, the only difference between me and George Floyd, the only difference between me and my twin, the only difference between me and Georgie, is the fact that I had more opportunities' ...later adding, 'If George would have had more opportunities, he might have been a pro athlete in two sports'" (Fernandez and Burch). Mr. Floyd was survived by five children, including a 6 year old daughter, and two grandchildren ("George Floyd").

The anniversary of Mr. Floyd's murder this month reminds us that a murder conviction isn't the final resolution. We must keep our focus on rectifying the structural inequities embedded in our society that contributed to Mr. Floyd's untimely death. As psychiatry educators, we must focus even more intently on the structural inequities embedded in psychiatry, where we hold the direct power to make change. Self-education, awareness, and anti-racist mindsets are a beginning, but they are not enough. Real change requires attention to the insidious ways that inequity is perpetuated by its structure in our everyday lives and practice.

During President Biden's first speech to Congress it was noted that for the first time we had a female Speaker of the House and a woman of color Vice President of the United States.

The question was then raised by politicians, pundits, journalists among others, “Is America racist?” That question, although valid, is beyond the scope of this article, but what is tangible and continues to be a recurring problem is the persistence of structural racism and healthcare disparities. Great strides have been made in American history such as the Civil Rights movement begun in 1955 and the passing of the Civil Rights Act of 1964 which outlawed discrimination based on race, color, religion, sex, national origin, and later sexual orientation and gender identity. However, in 2021, our great nation is still struggling with racism, misogyny, xenophobia, homophobia, transphobia, and an intolerance of people perceived as different from a cis-gender-white-male. These difficult truths are repeatedly demonstrated in our continual news cycle and seen played out in our healthcare system.

Health inequity continues to be a glaring issue which was made more apparent during the COVID-19 pandemic. African Americans are 2.4 times more likely to die from COVID-19 as compared to non-Latino Whites (Peteet). Healthcare disparities cannot be pinpointed to a single cause but implicit bias is a noted factor. There are still physicians who base their clinical skills on unsubstantiated beliefs or attitudes that African Americans have a higher pain tolerance than White counterparts and thus do not provide appropriate pain management to their African American patients (Pereda and Montoya). It has been shown in studies that Latinx patients typically receive inferior care related to several factors including barrier to access, substandard treatment, and poor follow up in comparison to Non-Latinx Whites (Mimi et al.).

In psychiatry, there has been a push to provide more culturally competent care while addressing structural racism. During his Presidential term in the American Psychiatric Association (APA), Dr. Jeffery Geller formed a *Task Force to Address Structural Racism Throughout Psychiatry* that was charged to provide educational resources about APA’s current

impact of structural racism on mental health and recommend actionable recommendations for change to eliminate structural racism in the APA. Unfortunately, we as psychiatrists still perpetuate mental health care disparities including diagnosing African Americans more often with Schizophrenia than their White American counterparts and significantly less often prescribing African Americans lithium and SSRI antidepressants while significantly more often prescribing them first-generation antipsychotics and any antipsychotic than patients of other racial groups (Gara et al.). In children, a longitudinal study demonstrated that minority children are more likely to be labelled unruly or disruptive and less likely to be diagnosed with ADHD as well as less likely to be medically treated than White children within the same age group (Morgan et al). Several studies including a systematic review have found concerning themes such as African American youth are more frequently diagnosed with psychotic and disruptive behavior disorders and less likely diagnosed with mood or substance use disorders; Latinx youth are more frequently diagnosed with substance use and disruptive behavioral disorders and less often with ADHD (Liang et al.).

As insurmountable as these structural inequities may seem, we all, as leaders in psychiatry, must dig deep for the persistence and tenacity to make change in the areas we oversee. We don't have the option to say, I've already tried *and it's too hard*. So, what can we do?

Despite the tumultuous year we have experienced, many physician leaders in organizations such as American Academy of Child & Adolescent Psychiatry, American Medical Association, APA, Association of American Medical Colleges, and AADPRT have acknowledged that not only is it important to stand in solidarity with communities of color, but to also be an antiracist. Many organizations such as AADPRT have begun the introspective dialog

of how to be truly an inclusive diverse and equitable organization. AADPRT has hired a diversity and inclusion consultant, Dr. Kenneth Hardy, who will lead multiple focus groups including program administrators (PAs), steering committee, and general members with an emphasis on examining member experiences within the organization. As an AADPRT member, you may sign up for a focus group, for AADPRT's DI committee or support your colleagues in doing so. However, incorporating ally and anti-racism practices are not only part of the national message but can be implemented within your own residency or institution.

Here are some beginning ideas:

As a program director, a chair or vice chair, a supervisor or a clinical psychiatrist:

- Review clinical practice at the individual / clinic / or institutional level level at your organization and identify inequities. Then, implement and test interventions. This could be a meaningful and impactful quality improvement project for your psychiatry residents or fellows (Cerdeña et al.).
- Train your residents and fellows, the next generation of psychiatry leaders, in structural competency (Neff et al.), advocacy (Li ), and anti-racism (Williams). Get them involved in your program or institution's Diversity and Inclusion committee if you have one; if not, form one.
- Re-examine your program's recruitment efforts. Are you screening out candidates based solely on the USMLE when there is evidence that standardized testing may reflect structural access rather than knowledge or aptitude? Are you focusing on prestigious medical school awards or honor societies when Black students are 6 times less likely to be inducted to the AOA? Are you aware that in the MSPE, faculty are more likely to

describe White medical students as “excellent,” “outstanding,” and “best,” while describing Black medical students as “competent” (Ross)? With these structural inequities in mind, can you change your assessment and rating of candidates? Can you include holistic review?

- Participate in changing the structural inequities faced by medical students of color as outlined above. For example, study the recommendation letters and honor society inductions at your medical school based on students’ race and suggest changes if needed. Review your own letters of recommendation for biased language and make adjustments.
- After the recruitment cycle, evaluate the total number and percentage of historically excluded and underrepresented groups in medicine (HEURGM) in the applicant pool, the percentage of HEURGM interviewees, the percentage of HEURGM that match into the program, and how inclusive HEURGM applicants felt the recruitment process was (Wilson et al.).
- Re-examine your program and institution’s culture. What is the experience of faculty, trainees and staff who self-identify as Black, indigenous and/or people of color (BIPOC)? What do BIPOC residents and faculty suggest to improve the program’s culture and educational structures? Does your institution have a mechanism for reporting and addressing mistreatment (Goldenberg et al.)?
- Mentor, sponsor, and champion BIPOC residents and faculty towards their leadership goals and begin to close the gaps in diversity at the medical school faculty and dean levels (AAMC). Critically evaluate current programs at your institution that ostensibly aim to improve diversity but may overburden BIPOC faculty and trainees by requiring extensive application processes for access to resources (e.g. mentorship, training in

academic writing, leadership coaching) that White faculty and trainees access without additional work.

- Participate in AADPRT's anti-racism, diversity and inclusion efforts, join a committee of interest such as the DI Committee, IMG Caucus, and/or the Allyship meetings offered monthly.

Of course, you can't do all, or really any of these things alone. The most important step in anti-racism is finding partners and creating a community that works together to make change. Let's make AADPRT that community.

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