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Commentary

Failure of leadership in U.S. academic medicine after George Floyd's killing by police and amidst subsequent unrest

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ABSTRACT

The horrific nature of George Floyd's killing by a Minneapolis Police Department officer on May 25, 2020 sparked an enduring stretch of nationwide protests against police brutality and in support of the Black Lives Matter movement. During periods of crisis, anchor institutions may exert leadership by issuing public statements to communicate shared institutional values, enhance morale, and signal direction in the face of crisis. In our analysis of public statements issued by 56 leading U.S. medical schools, we found that nearly all identified George Floyd by name, and a majority noted the role of racism or acknowledged the Black community specifically. Fewer referenced the act resulting in Floyd's death or made explicit reference to the police. Far fewer explicitly used terms denoting active support, like "antiracism" or "Black Lives Matter." Only a minority of institutions made reference to the killing of George Floyd by the police, and most failed to address this country's targeted, historically engrained, and sustained oppression of Black people through white supremacy. Thus, there remain significant opportunities for U.S. medical schools to exert meaningful leadership in public health.

On May 25, 2020, a Minneapolis Police Department officer killed George Floyd, a 46-year-old Black man, by kneeling on Floyd's neck for 9 minutes and 29 seconds while he was handcuffed and pleading for his life. The horrific nature of the killing – in the context of longstanding, disproportionate police violence against Black people [1-3] and an unsuppressed global pandemic of coronavirus disease 2019 that has disproportionately burdened Black, Latin, and indigenous communities in the United States [4, 5] – sparked an enduring stretch of nationwide protests against police brutality and in support of the Black Lives Matter movement now acknowledged to be the largest in U.S. history.

During periods of crisis, anchor institutions such as universities, hospitals, medical schools, and other organizations may on occasion exert leadership by issuing public statements to communicate shared institutional values, enhance morale, and signal direction in the face of crisis [6, 7]. In this *Commentary*, we describe statements issued by leading U.S. medical schools following George Floyd's killing and subsequent protests. These include U.S. medical schools identified in the top 50 ranking by either the *U.S. News and World Report* list of "2021 Best Medical Schools: Research" or the 2018 total dollar amount of research awards from the U.S. National Institutes of Health. Due to ties in the rankings, our total sample includes statements from 56 medical schools (**Appendix**; see also the publicly available Github repository: https://github.com/mkiang/statement_analysis). In a supplementary analysis, we collected additional statements from U.S. medical schools identified in the top 20 ranking by "social mission," as described by Mullan et al. [8] (**Appendix**).

After preprocessing the statements, we identified important elements each statement should contain based on defined criteria (**Appendix Table**): [1] use of victims' names (e.g., "George Floyd"); [2] reference to Black people; [3] reference to the police; [4] specifies the act resulting in Floyd's death; [5] explicitly naming racism (i.e., not "racial prejudice"); [6] explicitly using terms connoting active support (e.g., "Black Lives Matter", "antiracism"); [7] reference to negative sequelae resulting from racism; and [8] use

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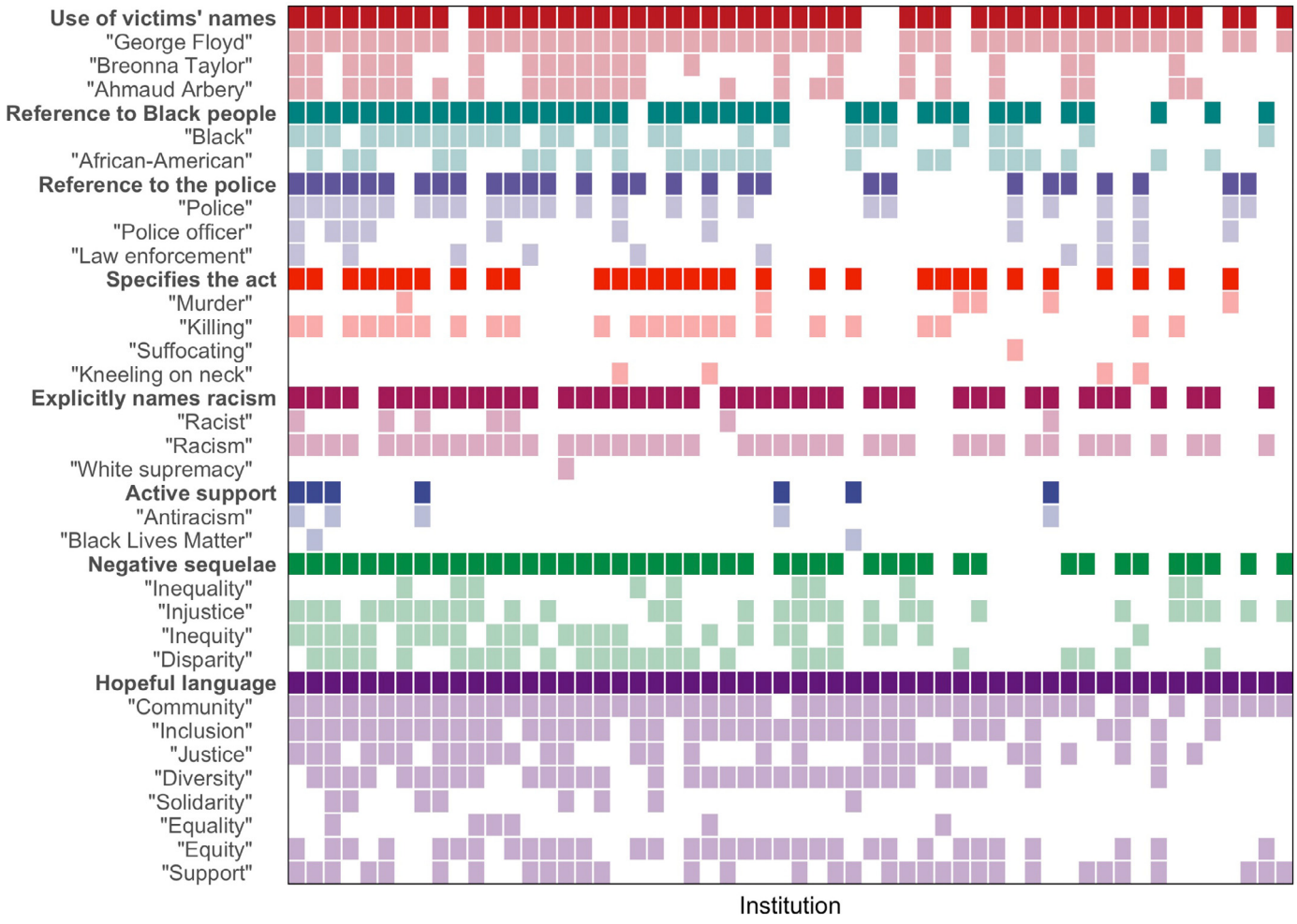

Fig. 1. Elements of statements issued after George Floyd's killing by police and amidst subsequent unrest in the United States (y-axis), by medical school (x-axis) ($n = 56$).

of hopeful language (e.g., "community", "inclusion"). We prespecified these elements based on theories of apology [9-11], the *#SayHerName* Campaign [12], the organizational behavior literature on apology effectiveness [13, 14], and the public health literature on structural racism [15]. For example, as lamented by England and Purcell [16], "Any reference to Rose's blackness was omitted, as was the whiteness of the police officer. Words like 'criminal justice' (let alone 'justice'), 'law enforcement,' 'race,' and 'racism' never appear" (p.24). This point led to the identification of categories such as "reference to Black people", "reference to the police", "explicitly names racism", and "hopeful language" (e.g., "justice").

All institutions released a statement in some form. By construction, the majority of statements in our sample were issued by medical school deans (50 [89%]). Most statements (46 [82%]) were available publicly. The median statement was issued on June 1, 2020 (interquartile range [IQR], May 31-June 2; range, May 29-June 2) – a week after Floyd's killing – and was 464 words in length (IQR, 371–560). Only three statements (5%) contained all of the prespecified elements (Fig. 1). Nearly all named George Floyd (50 [89%]); fewer named either Breonna Taylor (23 [41%]) or Ahmaud Arbery (26 [46%]). A majority acknowledged the Black community specifically (41 [73%]); the role of racism (43 [77%]); or negative sequelae resulting from racism, like "disparities" or "inequality" (45 [80%]). Fewer – slightly more than half – referenced the act resulting in Floyd's death (31 [55%]) or made any explicit mention of the police (29 [52%]). Only 7 (13%) explicitly used terms denoting active support, like "antiracism" or "Black Lives Matter." Most (45 [80%]) included references to negative sequelae resulting from racism like "disparities" or "inequality". All included hopeful language. In the supplementary analysis, U.S. medical schools ranked according to "social mission" [8] compared favorably on some metrics (e.g., mention of the police, use of words indicating active support) but compared equivalently or unfavorably on others (e.g., explicitly naming racism, reference to the Black community) (**Appendix**).

To summarize: in the days following the killing of George Floyd by the police, all of the leading U.S. medical schools issued public statements, but only a minority made reference to the police, and most failed to address this country's targeted, historically engrained, and sustained oppression of Black people through white supremacy. These are important failures because lack of positive leadership during periods of crisis can have persisting effects on confidence in institutions and leaders [17]. Thus, our study identifies opportunities for U.S. medical schools to exert meaningful leadership in public health.

It is possible that our focus on medical schools labeled as leading institutions according to ranking systems that are widely used but are of arguably limited relevance to social mission [8, 18] could have biased our quality assessments toward the null. However, in the supplementary analysis of U.S. medical schools with top rankings according to "social mission" [8], no clear pattern of improvement was observed. It should be noted here that the schools

represented in the top 20 of the Mullan et al. [8] "social mission" rankings include not only 3 of the 4 historically Black medical schools currently in operation but also a large number of medical schools located in southern and midwestern states with a low proportion of enrollment by students who are underrepresented in medicine but which contribute significantly to the country's training of primary care physicians and physicians who practice in health professional shortage areas. A second factor that could have biased our assessments toward the null is the fact that most academic medical institutions have failed to elevate Black people to the highest levels of institutional leadership [19]. Arguably statements written by Black faculty members in leadership – assuming away any constraints imposed by non-Black leadership at higher levels – would have been more likely to center the experiences of Black people, acknowledge the impacts of racism and racist policing on the Black community, or more forcefully committed their institutions in writing to actively supporting the Black Lives Matter movement and other antiracist initiatives [12, 16]. As noted by Nunez-Smith et al. [20], "Racial/ethnic minority faculty also often provide leadership in medical education, health policy, and research scholarship related to racial/ethnic health inequities" (p.852).

Despite these limitations, there remain important opportunities for leading medical and public health institutions to lead amidst a chronic public health crisis disproportionately affecting Black, Latin, and indigenous communities [1-3] layered upon an acute public health crisis now disproportionately affecting the same [4, 5]. Possibilities include: articulating a clear stance on anti-Black racism to affirm Black students, faculty, and staff and to motivate all students, faculty, and staff [1, 19, 21-23]; investing in financially costly initiatives (e.g., Boatright et al. [24] suggest a minimum of 3% of operating budgets, consistent with funding committed to diversity, equity, and inclusion initiatives at many U.S. for-profit corporations) to increase the proportion of Black, community college, and first-generation students [8], to narrow Black/white disparities in faculty pay and tenure [18, 19], to compensate Black faculty members for their work in supporting institutional diversity initiatives [25], to increase the proportion of Black faculty members in leadership [19, 20, 26], and to ensure a living wage for full-time and subcontracted staff [27]; training students in ways that do not contribute to the persistence of racism as a fundamental cause of Black/white health disparities [21, 22]; reviewing campus police practices to address racial profiling of Black students and faculty (however few there may be) and staff [1]; committing to financially costless initiatives such as the renovation of educational spaces that venerate the white men who have historically dominated the field [28]; and creating accountability structures that are not toothless to ensure that the crisis of the moment can be effectively harnessed to generate meaningful change.

These and other recommendations – which have long been the focus of advocacy efforts by Black faculty members and leaders in academic medicine [26] – if implemented, would substantially enhance the credibility of leading U.S. medical schools in their bids to be viewed as part of the solution rather than as part of the problem when it comes to racism in medicine, and in health care and higher education more generally. The public statements that are the focus of our analysis only represent these institutions' outward or public-facing action to address racism in medicine, but more costly and sustained efforts will be needed to effect changes that represent fundamental transformation. At the same time, however, as elaborated by Thomas [29], public statements can catalyze meaningful change by concretely defining an institution's commitment to anti-Black racism, preventing the general confusion that typically occurs about what matters for Black people's access to power and opportunities, and therefore molding true structural change. The extent to which such changes come to pass remains to be seen.

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Supplementary materials

Supplementary material associated with this article can be found, in the online version, at doi:10.1016/j.annepidem.2021.04.018.

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