Systemic Racism in Policing: A Top-Down Approach to Examining Vulnerabilities

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I have recently seen an uptick in posts, emails, and articles from people saying that systemic racism does not exist, and the prominent focus of these claims is policing. I find myself feeling baffled each time I see these claims and wonder if that person and I are living in two different realities. More recent commentary, however, has made me realize that some people may misunderstand what “systemic racism” means. These folks seem to think the term is akin to a conspiracy theory that assumes there are maniacal leaders at the top of police chains plotting to strategically and actively enact racism whenever they can. While this may happen, I do not believe it is the norm. (Racism is often far more subtle and insidious than that.) Nor does it accurately depict what is generally meant by “systemic racism.”

As a rookie resident at Lackland Air Force Base, I had to attend numerous trainings on patient safety, preventing medical errors, human factors, root cause analyses, after action reports, medical incident investigations, record keeping for risk management, etc., and this educational track continued throughout my tenure in active duty service and in my continuing education since.

Anyone in military healthcare or aviation is very familiar with the “Swiss Cheese Model of Accident Causation,” which is also frequently taught in civilian healthcare and aviation agencies. The Swiss Cheese Model of Accident Causation is a layered examination of how both active and latent failures/errors occur, and the model argues that these errors do not generally occur because of just one person. Rather, the system, leadership, and processes allow individual acts to result in failures/errors. If the system and all its subparts are designed correctly (i.e., for both effectiveness and the prevention of mishaps), bad outcomes based on individual acts are significantly reduced.

In historical models of incident investigation, the modus operandi was to look for a single point of failure – often the individual most significantly correlated with the adverse outcome. In current dialogue about inappropriate use of force in policing, this would be akin to the “bad apple” or “bad actor” argument. But merely attributing repeated incidents to the immediate actor is the ineffective professional equivalent of whack-a-mole. In contrast, the Swiss Cheese Model argument is “Were it not for a system that allowed it…” it likely would not have happened.

Let us look at a healthcare example to demonstrate. I recently served as an expert consultant on post-suicide litigation case. In my 56 page report, I highlighted all the layered and cumulative...
errors that contributed to/allowed for the sentinel event. Here is a sample of those layered and cumulative errors:

Layer 1: Organizational design and influences (latent errors)
- Overly bureaucratic system that operated in silos and potentiated blind spots
- Lack of requirement for standardized documentation
- Lack of standardized communication protocols across clinics and providers
- Lack of standardized procedures to conduct macro-level reviews of medical records
- Agency-wide follow-up and contact policies that are inconsistent with practice guidelines
- Agency-wide priorities that are out of step with what is important to/needed by the patient

Layer 2: Risky supervision practices (latent errors)
- Lack of oversight of documentation and care quality
- Inability to prove continuous education on practice guidelines
- Inconsistencies in orientation and training processes
- Pressure for productivity over quality
- Ineffectiveness in setting and sustaining quality standards

Layer 3: Situations allowing unsafe practices (latent errors)
- Lack of systematic communication between providers
- Walk-in clinics that did not communicate with primary provider and vice versa
- Little to no continuity of care due to provider turnover

Layer 4: Unsafe performance and individual actors (active errors)
- Subpar and inaccurate documentation
- Failure to follow clinical practice guidelines
- Failure to properly recognize and mitigate warning signs
- Lack of follow-through
- Failure to listen to and act on what the patient said was important to them
These layers are demonstrated in the below graphic. Each layer of error contributed to and allowed for the patient’s death.

(Snydeman, 2013)

In the Swiss Cheese Model, there is a top-down approach to risk mitigation, and prevention of errors must start by designing a system that disallows error. Examples of this top-down approach include redundancy (e.g., having multiple medical professionals check and say aloud the name and dosage of the drug they are administering, having patients and multiple medical professionals state aloud which side is to be operated on and what procedure is taking place), peer reviews of records, incentives and empowerment for all personnel to speak up when there is a problem, regular trainings to prevent behavioral drift, accountability for deviations from standards, etc.
If system-level prevention is not properly designed and executed, errors will happen – and at a rate that is much higher than in properly designed and executed systems. Human factors will always exist in healthcare settings. A single mom may have been up all night with a sick child – and then presents to her nursing job the next day in a sleep deprived state. If the system does not prevent it, her sleep deprivation increases the odds of administering the wrong medication to a patient, which could be fatal. When the system builds in preventative redundancy systems, there is a much higher probability that one of the nurse’s colleagues will catch and correct this error before it occurs. A surgeon may be mentally distracted by the tumor that was just found in her spouse’s abdomen last week, and in this distracted state, she may operate on the wrong limb of a patient. When the system builds in prevention and redundancy, the surgeon’s distraction alone will not result in a medical error, as the entire medical team will have a role in the hospital’s standardized checks and balances.

Paramount to the top-down approach is entry at the door of the medical facility – a proper vetting of personnel, which is why accredited medical facilities generally have internal credentialing departments. These departments are tasked with verifying the new hire’s education, verifying licensure, conducting criminal background checks, investigating the new hire’s history of professional complaints and/or disciplinary action, verifying continuing education, etc. Failure to properly conduct this new hire process increases the potential for harm to patients, the facility’s likelihood of being deemed liable for harm, and an erosion of standard of care (i.e., à la behavioral drift, group think, and/or contagion).

This same Swiss Cheese approach to mishap prevention is ubiquitous in aviation and is illustrated in the graphics below.
So based on my experience in healthcare and working with aviation communities, when I think about systemic racism in policing, I am thinking about the Swiss Cheese Model, risk mitigation, root cause analyses, human factors, active errors, and latent errors. I am not, on the other hand, thinking about some calculating police chief pulling the levers and turning the dials of strategic racism. When I think about systemic racism in policing, I am thinking about a system that allows for race-based latent failures/errors. I am thinking about holes in the various layers that make...
room for “bad apples” and “bad actors” to execute their biases and/or racism in the communities they are sworn to serve and protect.

I have accumulated years of experience working with and treating a wide range of law enforcement officers – from military cops to federal agents to officers working for local precincts. With this experience and within the mental metric of the Swiss Cheese model, I believe it would be beneficial to examine the following layered questions about the systems (and its subparts) in which police officers work.

Layer 1: Organizational design and influences (latent errors)

- Are current orientation and training standards/requirements for new hires sufficient to do this important/high-risk job?
- Is the vetting process for new hires sufficient?
- Are agencies investigating a new hire’s history of conduct and complaints with prior agencies?
- Are personality disorders being sufficiently assessed, and are personality disorders disqualifying?
- Are there standardized, effective, continuous trainings for established officers?
- How are officers’ compliance with trainings and standards analyzed and rated?
- Does the agency set standardized quality and prevention standards?
- If so, what is the mechanism for periodic reviews?
- Are agencies sufficiently funded to complete all of the above, and is funding being prioritized/allocated to mechanisms that prioritize quality, ethical policing?
- What influence do unions have over standards?
- Are agencies emphasizing a culture of ends over means?
- Do agencies intentionally or unintentionally promote an us-versus-them culture?
- Do agencies set cultures wherein police-involved fatalities are seen as “part of the job” or incidents to analyze and learn from?
- Are there sufficient, agency-wide accountability and disciplinary metrics?
- Are agencies empowered to enact robust accountability and disciplinary actions without undue influence from unions?
- Are there standardized remediation programs?
- Are reviewers/investigators of incidents objective?
- Is Internal Affairs objective?
• Why are there not national policing accreditation and oversight organizations (such as the TJC for medical facilities)?
• Does this lack of oversight and accreditation prevent individual precincts from incorporating best practices that are based on objective science/data?
• Does the agency acknowledge the existence of societal discrimination and bias and its risk of appearing in policing practices?
• Is reducing and/or ameliorating discrimination and bias in the agency’s operational priorities?

Layer 2: Risky supervision practices (latent errors)
• What are supervisors and other members of leadership modeling for officers?
• Are supervisors holding officers accountable for deviation from standards?
• Are supervisors empowered to hold their officers accountable?
• Are supervisors empowered to set and enforce quality standards?
• Are supervisors empowered to denounce and discipline officers for verbal or physical acts of discrimination and bias?
• How are supervisors evaluated?
• Are supervisors receiving the same continuous trainings as their officers, and how are they ensuring their officers’ compliance with evolving standards?
• Are supervisors providing appropriate oversight of their officers’ work?
• Are top-level leaders prioritizing re-election over ethical, high quality policing practices?
• Are supervisors emphasizing de-escalation procedures and conducting root cause analyses after incidents to examine appropriateness of use of force?
• Are supervisors talking to their officers about discrimination and bias in policing before it happens?
• Are supervisors setting a cultural expectation of non-discriminatory policing?

Layer 3: Situations allowing unsafe practices (latent errors)
• Are officers being allowed to work excessive hours that compromise their judgment?
• Are precincts understaffed and unable to provide appropriate back-up/assistance to officers in high risk situations?
• Is there a culture of pressure to handle calls aggressively and/or without appropriate assistance?
• Are officers being over-tasked with calls that result in them cutting corners?
• Are officers being sent on calls for which they are not properly trained?
• Are officers properly trained in responding to mental health calls?
• Are officers backed by mental health professionals to respond to these calls?
• Are officers across precincts properly outfitted with sufficient resources/equipment to respond to all levels of risk and/or respond with nonlethal means?
• Are officers under other pressures that take priority over de-escalation techniques?
• Are officers working in a culture that promotes holding their fellow officers accountable on-the-spot?
• Are morally-compromised officers being allowed to operate with impunity (or being incentivized to do so), which makes it hard for other officers to promote if they operate under best practices?

Layer 4: Unsafe performance and individual actors (active errors)
• Are officers harboring discrimination and bias on the force?
• Are overly aggressive officers on the force?
• Are rule breakers and renegades on the force?
• Are morally-compromised officers on the force?
• Are habitual offenders (re: complaints from the public, inappropriate use of force, etc.) on the force?
• Are overly scared, jumpy officers on the force?
• Are one-time, low threat offenders properly retrained and rehabilitated?

While not an exhaustive list of questions to analyze policing agencies vis-à-vis the Swiss Cheese Model, the above questions help demonstrate how policing systems allow for discriminatory practices to occur in their interactions with the public. And this is precisely what is meant when we are talking about systemic racism in policing. It is racism that occurs within, is facilitated by, and fails to be corrected by a system.

In contrast, systemic racism does not mean that every member of the system is racist or would engage in discriminatory or biased acts. It does not mean that the system is itself racist or that the system intends to promote racism or discrimination.

Said again, systemic racism is racism that occurs within, is facilitated by, and fails to be corrected by a system.
To provide yourself an honest assessment of whether we should settle on the status quo in policing and not conduct root cause analyses of policing agencies’ use of force, ask yourself this: Would you want to receive care at a hospital that may or may not acknowledge its own employees’ failures/errors? Would you want to be admitted to a hospital that refuses to look at itself and instead blames its significant pattern of patient fatalities on “bad apples” or “bad actors”? Would you trust a hospital that defensively responded to calls for accountability by claiming that you were anti-doctor?

The stakes are high in policing, and law enforcement officers have a demanding and risky job. And we rely on them to come to our aid in some of the most horrifying moments in our lives. This is precisely why we need to do better.

The relationship between police officers and the communities they serve needs to be healed, and we cannot accomplish this by facilitating the status quo. This healed relationship can keep both our officers and our communities safer.

References
