Actively Caring for the Safety of Patients
Overcoming Bystander Apathy

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PROBLEM: The Institute for Safe Medication Practices (ISMP) has often been invited to assist organizations in their analysis of sentinel events. These unanticipated events can result in death or serious physical or psychological injury to a patient; they are not related to the natural course of the patient’s illness.

During discussions with the ISMP, health care practitioners periodically shared an uncomfortable truth regarding these untoward events: they were not surprised that the errors happened. Many practitioners told the ISMP that it was only a matter of time before a serious adverse event occurred in their organization. Pharmacists at the ISMP asked these practitioners what they tried to do to prevent an event when they knew that a particular hazard existed. The practitioners divulged that they had not personally reported the problem to their supervisor, completed an event or near-miss report, or intervened to prevent such an event; however, they felt sure that others knew about the problem.

When we visited organizations to conduct prospective risk assessments, we asked staff members about what types of medication-related accidents they believed were “waiting to happen.” Many practitioners gave us thoughtful answers, but few had reported their safety concerns to a supervisor or had tried to correct the problem. They also emphasized that others knew about the problem.

All of these professionals were very concerned about patient safety. They were devastated by the harmful events that occurred, and they did worry about the possibility of future events. They discussed many incidents in which they “went the extra mile” for their patients.

So why do otherwise caring practitioners fail to report safety hazards until after an error has occurred? Why do they not intervene to correct the hazards they see or notify others regarding the problem? Psychologists say that bystander apathy plays a role in these failures.

The murder of Catherine (Kitty) Genovese in 1964 brought public attention to the phenomenon of bystander apathy. Ms. Genovese was raped and stabbed outside her New York City apartment building. As she screamed for help, lights went on and windows opened in the neighborhood. The attacker fled, but when he saw that no one was coming to help Ms. Genovese, he returned and continued the attack for another 30 minutes until she was dead. The first and second attacks were witnessed by 38 neighbors, but no one intervened or, reportedly, called the police until after the attacker left. When questioned, the 38 observers could not explain why they did not call police earlier. Their apathy was first attributed to big city life, where indifference to others seemed rampant. But hundreds of studies have since concluded that bystander apathy is not a result of indifference; it is caused by a belief that others in a group who see the same risks will intervene.

Studies show that people are less likely to intervene when others are present and able to help. When groups of people are involved, the responsibility to act is diffuse rather than personal. People can easily convince themselves that their help is not needed, that someone else will act. This applies not only to emergency situations, as in the Genovese case, but also to nonurgent situations.

The finding that people tend not to act when they can share responsibility with others rings true in most work settings, including health care. Bystander apathy plays a particularly detrimental role in patient safety, as noted with a failure to report risks that eventually lead to a sentinel event. A culture of safety can be achieved only if all employees intervene regularly to protect and promote patient safety. Everyone must assume responsibility and should never wait for someone else to act; each person must actively care about patient safety.

SAFE PRACTICE RECOMMENDATIONS: An individual typically makes five sequential decisions before acting on a perceived safety problem. The decisions are influenced by the nature of the problem, the presence of others and their reaction to the problem, and relevant social norms. The following decision points suggest ways to decrease bystander apathy.

Step 1: Is something wrong?

The first step that can help to promote actively caring about safety is to notice that something is not right. Most health care practitioners are well aware that medical errors are a significant threat to patient safety; however, in the context of a hectic environment, busy practitioners can quickly learn to tune out irrelevant stimuli and thus may overlook, fail to report, or fail to correct safety hazards they encounter every day. To ensure their engagement in actively caring behavior, staff members need to become skilled in identifying safety hazards and in maintaining a healthy preoccupation with the risk of errors. These skills can be improved in simulation exercises.

Step 2: Is my help needed?

If people perceive that the need to intervene is not blatantly obvious, they tend to deal with a questionable situation by observing their colleagues. Unfortunately, with everyone watching for action from others before they intervene, appropriate steps might never be taken. Social context also can have a dramatic effect on whether people decide that their help is needed or even whether there is a problem that needs to be addressed.

In one of the first studies that defined this problem, students were left in a room into which pungent smoke was pumped. When each student was alone in the room, 75% quickly left to report the smoke, but only 10% of the individual students who were in a room with two passive strangers left to report the smoke. Many students concluded that nothing was wrong, because the two strangers did not get up to leave. Each student tried to “stay cool,” looking around for social continued on page 319
cues to determine whether a problem existed. The students who did not leave the room developed a shared illusion of safety with the passive strangers.

There are several ways to counteract the tendency toward inertia in groups:

1. The staff should feel that they belong to the groups with whom they work. Bystander apathy is lessened when people know one another and have developed a sense of belonging or mutual respect from prior interactions.1

2. Organizations should help inculcate a sincere belief in and a commitment to interdependence among staff. A social norm of collaboration, rather than working independently, should be promoted.1

3. Organizations should strive to build synergy among workgroups. When synergy is achieved, the final outcome of a system is greater than the sum of its parts (individuals). However, psychologists have described a group phenomenon called “social loafing,” in which the whole group is not greater than the sum of the parts (individuals).1

In one study, researchers measured the effort exerted by eight people, first independently and then together, when they pulled a rope in a simulated tug of war.4 The group effort was found to be equivalent to only half of the sum of the eight individual efforts. The subjects worked harder alone than as a team, so group synergy was not achieved. Group synergy is possible only when group members know each other, agree on goals, and work well as an interdependent team. Individuals also need to feel a sense of personal responsibility for the team’s efforts. They need feedback about their contributions to safety and rewards for a job well done in order to build a sense of personal responsibility for the team's safety record.1

4. Each person should lead by example. To promote actively caring for safety, employees must demonstrate these behaviors consistently, sending the message that “patient safety begins with me.”

Step 3: Is it my responsibility to intervene?1,3

In a group setting, it is easy to assume that safety is someone else’s responsibility; however, people often take action if their responsibilities are clear and if they voluntarily pledge to meet them.1

A theft on a public beach was the subject of one early study that demonstrates this concept. Researchers posing as vacationers randomly asked individual sunbathers to watch their possessions while they swam in the ocean.1 A short time later, a second researcher approached the man’s belongings and snatched his radio; 94% of the sunbathers who promised to watch the man’s belongings intervened, often dramatically, but only 20% of the bystanders who were not specifically asked to watch reacted to the obvious theft. A social norm must be established so that everyone shares equally in the responsibility to keep patients safe.

Steps 4 and 5: What should I do? When should I do it?1,3

These steps point to the importance of education and training so staff members feel capable of reporting and managing safety risks. When people know what to do, they do not fear making a fool of themselves and are less likely to wait for another person to take action. Education gives staff the rationale and principles behind particular safety interventions and empowers them to take action, leading to a sense of ownership.1 When people receive tools to improve safety and believe that the tools will be effective, the risk of bystander apathy decreases.

In summary, people who have learned how to take action through relevant education and training are likely to be the most successful in actively caring for safety.

REFERENCES