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Letter to Editor

Prioritizing just culture: A call to action for patient safety

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Recently, patient safety incidents become a critical global issue, affecting patients in both developed and developing countries across all areas of healthcare services (1). Patient safety refers to the prevention and improvement of adverse outcomes or harm caused by healthcare processes, with the aim of ensuring an environment that positively impacts patients, their relatives, and healthcare staff (2) and Patient safety culture (PSC) is an integral part of improving patient safety and delivering high-quality healthcare services (3). PSC refers to the shared values, norms, and beliefs of a healthcare institution that affect workers' actions and behaviors (4).

Despite advancements in healthcare, the level of safety in Health care System remains unsatisfactory (5). In 2020, the World Health Organization (WHO) reported that 134 million adverse events occur annually in hospitals (6). Nevertheless, it is reported that healthcare professionals often refrain from reporting these incidents due to the criticism and stigma surrounding patient safety events (7).

To address this issue, many countries have emphasized the importance of a "no-blame culture" (8). The concept of a no-blame culture was first introduced as one of the five fundamental elements of safety culture by James Reason in 1997 (9). More recently, this no-blame culture has been recognized as the idea of a just culture or a culture of accountability. Just culture refers to an environment in which members of an organization are encouraged to exchange critical safety-related information. While engaging in such exchanges, they receive feedback and support, ultimately increasing trust among members (8).

Implementing this culture in hospitals strengthens the incident reporting system by creating an environment where individuals can openly report patient safety incidents. Additionally, organizational control enhances staff capabilities and contributes to effectively addressing issues related to patient safety incidents (8, 10). Previous studies have shown that a culture of accountability increases the number of reported patient safety incidents, helps healthcare staff learn from reported events, reduces the likelihood of incidents that threaten patient safety, and ultimately improves patient safety (8, 11, 12).

In fact, it must be noted that a just culture requires an impartial approach to judging human errors and is designed to build organizational trust so that adverse medical events (errors) are reported and rectified before they combine with other errors and result in patient harm or death (9). However, a just culture is still not actively implemented in many countries (13), which may be due to a lack of proper understanding of the concept. Trust in error reporting within a just culture is influenced by organizational factors (management style, open error handling, patient safety focus), team dynamics (supervisor relationships, role clarity), and individual experience (clinical confidence, fear of blame, familiarity with reporting systems) (14). In a just culture, healthcare professionals are not only accountable for their actions and choices but are also responsible toward one another (10, 15, 16).

Essentially, when errors are viewed systemically rather than individually, it is understood that no single person is solely to blame for an error. Simply punishing one

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individual does not resolve the problem or prevent the recurrence of the error. Although it is natural to react with strong emotion when a patient dies or is severely harmed due to an incident, it must be recognized that as long as a climate of fear and intimidation prevails among healthcare staff—discouraging error reporting—the errors will go unreported. Consequently, root cause analysis, identification of unsafe acts, and corrective actions to prevent future incidents will not be carried out, which can ultimately threaten patient safety.

Since accurate perceptions of safety culture are a fundamental prerequisite for improving the quality of nursing care (17), therefore, it is recommended that healthcare managers and policymakers pay more attention to the issue of a culture of accountability, which is an essential yet often overlooked component of patient safety culture. They should create environments in healthcare settings that foster a just or accountable culture, paving the way for a shift from a pathological safety culture to a productive and positive organizational culture focused on patient safety. Finally, strategies for institutionalizing a Just Culture within healthcare systems may include: leadership commitment, education and training, accountability, and open communication (18).

In conclusion, it is recommended that health leaders adopt a transparent and non-punitive approach to reporting and learning from errors, define clear processes, and employ fair methods to identify human and systemic errors. They should provide exemplary leadership to reduce employee fear and encourage error reporting, create policies that support a culture of patient safety, focus on shared responsibility to prevent unfair accusations and utilize reliable tools to measure patient safety, all of which can contribute significantly to promoting a Just Culture.

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Conflicts of interest

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