A just culture is the balanced approach to safety

By Donna Walsh & Julie Greenall

In health care, as in other industries, a safety culture is essential, meaning that individuals, teams and organizations need to have a constant and active awareness of the potential for things to go wrong. It is also a culture that is open and fair, and one that encourages workers to speak up about mistakes. In a safety culture, organizations are able to learn from mistakes.

A difficult but fundamental aspect of a safety culture is the need to accept that people, processes, equipment and systems can fail. By accepting this, organizations can change their focus to develop defences and contingency plans to cope with real and anticipated failures. The term 'Just Culture' has been coined to describe an organizational philosophy that is fair to workers who make mistakes, and is effective in reducing safety risks.

James Reason describes a Just Culture as an atmosphere of trust in which workers are encouraged, even rewarded, for providing essential safety-related information (reporting), but in which it is also clear where the line must be drawn between acceptable and unacceptable behaviour. He adds that an effective reporting culture depends on the way organizations handle reports of error and hazardous situations. 'Name, shame, and blame' cultures can lead to a lack of reporting due to fear of reprisals thus driving invaluable information about hazards underground. However, a completely non-blame culture is neither feasible nor desirable. Most people rightly expect some level of accountability when a mishap occurs.

David Marx, a leading authority on Just Culture in the United States describes it this way:

"On one side of the coin, it is about creating a reporting environment where staff can raise their hand when they have seen a risk or make a mistake. It is a culture that rewards reporting and puts a high value on open communication – where risks are openly discussed between managers and staff. It is a culture hungry for knowledge.

On the other side of the coin, it is about having a well-established system of accountability. A Just Culture must recognize that while we as humans are fallible, we do generally have control of our behavioural choices, whether we are an executive, a manager, or a staff member. Just Culture flourishes in an organization that understands the concept of shared accountability – that good system design and good behavioural choices of staff together produce good results. It has to be both."

The road ahead for a Just Culture in health care may be bumpy. Historically when patients have been harmed as a result of their care, attention has been directed to the actions of the individual practitioners responsible for their care. This punitive approach has often been supported by the tone of the media reporting of these events. However, evidence that culture within health care is changing can be seen in recent reports of medical errors where senior hospital leaders have publicly supported the staff involved in harmful events.

As we move forward, health care practitioners can learn valuable lessons about safety culture by examining the work of other industries that have adopted the Just Culture philosophy. The collaboration of a number of industries has led to a Just Culture community: www.justculture.org. This holds promise for the future in the broader adoption of a Just Culture and ultimately for patient safety.

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