Just culture in healthcare: in search of a solid foundation for justice

Cultura justa en salud: en busca de una base sólida para la justicia

Cultura justa em saúde: em busca de uma fundamentação sólida para a justiça

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1 Maristela Santini Martins
2 Marcelo José dos Santos
3 Edenise Maria Santos da Silva Batalha
4 Andresa Gomes de Paula
5 Hércules de Oliveira Carmo
6 Vagner Ferreira do Nascimento

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Patient safety incidents are globally recognized as a serious public health problem, resulting in deaths, disabilities, and profound suffering that extends to patients, families, healthcare professionals, organizations, and society at large. In response, healthcare organizations have sought models from high-reliability organizations such as aviation and nuclear energy. In these settings, where the risk of failure is critical, the focus is on systemic safety rather than individual blame. Within this context, David Marx consolidated the concept of Just Culture (1), initially theorized by James Reason in 1997 as a pillar of safety culture in high-risk industries, and operationalized it, transforming the concept into a framework applicable to healthcare (2).

In his seminal work *Patient Safety and the "Just Culture": A Primer for Health Care Executives*, Marx redefines Just Culture as a model of differentiated accountability, grounded in the dual principles of systemic learning and proportional accountability. His approach, adapted from aviation to healthcare, challenges the simplistic dichotomy between punishment and impunity: inadvertent human errors should lead to root cause analysis rather than sanctions, whereas reckless or deliberate violations require individual accountability (1). This perspective acknowledges that over 80 % of errors have organizational roots, which may include process failures (e.g., outdated protocols or uncoordinated workflows), design flaws (e.g., counterintuitive

1 Escola de Enfermagem da Universidade de São Paulo (USP), São Paulo, São Paulo, Brazil.
ORCID: https://orcid.org/0000-0002-0730-3923
E-mail: maristelasanti@usp.br
2 Escola de Enfermagem da Universidade de São Paulo (USP), São Paulo, São Paulo, Brazil.
ORCID: https://orcid.org/0000-0001-5123-8797
E-mail: mjosan1975@usp.br
3 Universidade do Estado da Bahia (UNEB), Salvador, Bahia, Brazil.
ORCID: https://orcid.org/0000-0003-0014-9529
E-mail: emssilva@uneb.br
4 Escola de Enfermagem da Universidade de São Paulo (USP), São Paulo, São Paulo, Brazil.
ORCID: https://orcid.org/0000-0001-5077-7908
E-mail: andresa.paula@usp.br
5 Escola de Enfermagem da Universidade de São Paulo (USP), São Paulo, São Paulo, Brazil.
ORCID: https://orcid.org/0000-0002-6996-4233
E-mail: hercules.enf@usp.br
6 Universidade do Estado de Mato Grosso (UNEMAT), Barra do Bugres, Mato Grosso, Brazil.
ORCID: https://orcid.org/0000-0002-3355-163X
E-mail: vagnernascimento@unemat.br

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technologies or risk-inducing physical layouts), and systemic overload (e.g., understaffed teams or excessive cognitive demands). Such failures demand structural institutional responses rather than individual blame (2).

The originality of Marx's model lies in his behavioral taxonomy of the "Four Evils," which categorizes human actions by degree of culpability: human error (inadvertent or honest mistakes), negligence (failure to meet expected standards), recklessness (conscious disregard of risks), and intentional violations. This classification serves as an ethical compass for institutions: while human errors require system redesign, reckless or deliberate acts justify sanctions. Marx argues that traditional punitive systems, by criminalizing honest mistakes, inhibit transparency and perpetuate failures (1). This critique is echoed by Dekker, who emphasizes how blame cultures sabotage organizational resilience (3). Marx's proposal (1), therefore, establishes a dialectical balance in which procedural justice becomes a condition for safety, and fairness serves as the foundation for collective trust.

Contemporary conceptions of Just Culture propose viewing error as a learning opportunity, focusing on systemic analysis and identifying process or system failures that contributed to its occurrence. The model centers on balancing professional and system accountability, distinguishing between inherent human fallibility, risky behavior, and recklessness. It transforms the organization into an open environment that fosters transparency and open communication. This process approaches the analysis of adverse events and incidents comprehensively and systematically, enabling accurate mapping of the sequence of events and identifying the factors that truly contributed to the failure. Such an approach is crucial for contextualizing and analyzing errors, aiming for equitable and fair accountability and, consequently, enhancing patient safety.

Promoting psychological safety becomes fundamental, seeking a balance between learning from errors and applying disciplinary measures when necessary. This approach aims to ensure that professionals feel comfortable reporting adverse events and incidents. The goal is to create conditions that legitimize interventions through sanctions, when applicable, while promoting the restoration of individuals involved in the event (4).

However, if Just Culture emerges as a prominent pathway for addressing safety incidents, so frequent in healthcare, it must be acknowledged that its effective implementation requires addressing moral and safety issues essential for fostering justice in the workplace (4). The absence of attention to fundamental aspects, such as the existence of fair and legitimate regulations, procedures, and rules, as well as ethical and impartial incident analyses free from biases related to hierarchy and power structures, can render Just Culture mere rhetoric, devoid of practical effectiveness.

This reflection imposes a necessary consideration of the main conceptions of Just Culture, which imply different visions of justice: retributive and restorative. Both influence decision-making in healthcare and deserve an in-depth discussion in the context of safety incidents.

Retributive Just Culture focuses on a corrective approach, seeking individual accountability for acts causing the incident (5). This model of justice determines appropriate treatment for those who violate certain behavioral standards and therefore concentrates on errors or infractions committed by individuals (4). In this conception, rules and standards to be followed are strongly emphasized, along with the understanding that compliance is sufficient to ensure that safety incidents will not occur. The focus lies on who committed a given action, analyzing which rule was broken, and determining the appropriate penalty to correct the situation (5). At times, this approach may be

limited to the relationship between superior and subordinate, clearly establishing who holds the power to determine procedures following an incident (4).

Restorative Just Culture, in turn, focuses on restoring individuals and relationships after an incident. This conception seeks to understand why people acted as they did and why such actions made sense to them at that moment. Therefore, it proposes that if an error or violation causes harm, the response should aim at healing and alleviating suffering. This approach to justice and accountability is more inclusive than the retributive one, recognizing that multiple parties may be harmed by an incident: the first victims (patients and their families), the second victims (the professionals involved in the event), colleagues, the organization, and even the community as a whole. This model assumes that harm creates needs, and needs create obligations, which must be defined collaboratively. Restorative approaches welcome multiple voices and are more likely to identify the deeper conditions that allowed the incident to occur (4).

Although Just Culture represents the ideal scenario for healthcare institutions, its practical implementation requires a profound reflection on the meaning of "justice" within the term itself. Apparently, the term "just" was introduced in this context with an assumed understanding but without explicitly aligning with classical references of justice, such as Dekker's model or other established philosophical theories (3,4). This conceptual ambiguity creates a paradox: while the model theoretically promotes proportional accountability, in practice, many institutions reproduce punitive biases under the label of "justice," especially against vulnerable professional groups. The gap between theory and practice exposes a central issue: how to build truly just systems when the very concept of justice lacks coherent philosophical grounding within patient safety and Just Culture?

Justice is one of the oldest and most fundamental principles of humanity, present in philosophical, legal, and ethical traditions since the dawn of social life. From Plato and Aristotle to contemporary bioethics, justice has been conceived as the pillar sustaining human coexistence, social organization, and the protection of the most vulnerable. In healthcare, this principle gains even greater urgency as it concerns the equitable distribution of resources, responsibilities, care, and reparations. In times of increasing complexity in health systems, and in the face of errors, adversities, and inequalities, reflecting on the meaning of justice, especially under the lens of a "just culture," is not merely a theoretical exercise but an ethical imperative to transform care, protect professionals, and ensure patient safety.

Despite its undeniable merits, both the theory and practical implementation of Just Culture face substantial objections depending on the perspective considered. As Dekker highlights (6), the distinction between "human error" and "reckless behavior" is notoriously thin and subjective, often distorted by outcome bias. In this bias, the severity of consequences, rather than the intrinsic nature of the act, determines the organization's reaction. Furthermore, the definition of what is considered acceptable falls to committees or managers, whose judgments may be influenced by external pressures from the media, public opinion, or the legal system, generating inconsistencies and compromising the promise of fairness.

Although Just Culture operates at the organizational level, it is crucial to recognize that the organization exists within a broader social context governed by a punitive legal system and potentially sensationalist media. Following a severe adverse event, external pressure to identify and penalize a culprit can be overwhelming, coercing the organization to abandon its principles to appease such demands.

Added to this complexity is the dilemma of accountability. On the one hand, not every error can be attributed exclusively to a systemic failure; on the other, excessive focus on the system may paradoxically neglect individual accountability when it is indeed warranted. The model explicitly prescribes what should not be punished but remains notably vague in defining what constitutes "just punishment" for genuinely negligent conduct. This ambiguity can foster, at one extreme, a perception of impunity and, at the other, arbitrary punitive decisions by management.

Implementing an authentic Just Culture requires profound cultural transformation, a process that takes years and demands unwavering commitment from senior leadership. It is common for organizations to adopt the rhetoric of the concept without altering underlying practices, creating a mere "paper culture" in which employees remain skeptical about guarantees of non-punishment.

Trust, the foundational pillar of the model, is a fragile construct. A single incident of unjust punishment can destroy years of dedicated work and set back decades of progress in reporting willingness. Finally, in deeply hierarchical cultures such as healthcare, fear of challenging superiors or exposing colleagues may persist even with a formal Just Culture policy. The model prescribes "non-punishment," but it does not necessarily dismantle the power dynamics that silence professionals, thus weakening its application and the trust it seeks to build.

It follows, therefore, that the challenge of implementing a Just Culture goes far beyond adopting a protocol or behavioral taxonomy. It requires healthcare organizations to grapple with the complex philosophical question of what it means to be just. Without a deep and ongoing dialogue involving all voices, managers, professionals, patients, and the community, and anchored in clear ethical principles, Just Culture will remain a noble ideal, yet distant from practice. Nursing, as the profession on the frontline of care, must lead this critical reflection and advocate for health systems that are not only safe but truly just.

IA Declaration

We inform you that the text was submitted to artificial intelligence (ChatGPT) for assistance with grammatical review and organization, without interfering with its scientific quality, originality, or authorial characteristics.

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