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EDITORIAL

Understanding Honest Mistakes, Second Victims and Just Culture for Patient Safety

Errores Honestos y Segundas Víctimas: Hacia una Cultura Justa para la Seguridad del Paciente

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After the Chernobyl nuclear disaster in 1986, the relationship between safety culture and the risk of adverse outcomes came to the forefront.[1] Since then, industries requiring high reliability, such as energy, chemical or petrochemical industries, transportation, and healthcare, have understood the impact of their members' attitudes on operational safety.[2–4]

Safety culture refers to the set of norms, beliefs, values, attitudes, and assumptions inherent in the daily functioning of individuals, teams, or organizations. It reflects whether safety is considered a core value in their activities, how they identify and implement safe practices, and how they respond to safety incidents.[5–8] Creating an environment of transparency and trust (psychological safety [9]) involving all staff, along with promoting the principles of a just culture (supporting professionals after incidents), have been identified as critical elements of a safety-generating culture.[10,11] Conversely, complacency, taking things for granted, fear of speaking openly about occurrences, ignoring professionals' fatigue or mental and physical overload, contribute to safety incidents.

Following a significant event in these industries, detailed analysis is conducted, and recommendations for procedures, behaviors, and equipment are generated, ultimately becoming guidelines.[12,13] However, changing attitudes is not as straightforward. To advance from a reactive (or, at best, proactive) culture to one that generates safety,[14] there are essential issues to consider.

I. Safe practices have been implemented and expanded, but intra and extramural attitudes within healthcare institutions have not undergone the expected changes. The widespread belief that removing the rotten apple from the basket will solve everything is unrealistic and poses a risk to patient safety. The view of errors as ''deviations from the norm'' needs to change because it hinders the implementation of safe practices, risk management, and victimizes professionals.[15–17]

A **broad social commitment** is necessary to consolidate progress and promote a safety-generating culture from all angles.[18] While intramural activities have been diverse and effective, extramural efforts are still lacking and should be addressed. This commitment could begin in higher education, by reviewing the current deficiencies [19] in the training of future generations of healthcare professionals regarding patient care quality and safety.

II. To foster a safety-generating culture, leaders must strike a balance between the system's responsibilities, individual responsibilities, and the environment. This involves ensuring accountability and empowering professionals to learn from their mistakes.[20] An open and honest environment is crucial, where **professionals feel evaluated and treated in a consistent, constructive, and fair manner**, particularly when directly impacted (second victims [21]). For professionals, it means implementing the ''duty of care''

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by following procedures, guidelines, and standards correctly and seeking ways to create increasingly safe environments.

III. Evidence suggests that applying the principles of a just culture [22–24] can lead to more profound and lasting transformations in safety culture, **managing inherent human fallibility in complex environments**. These principles, based on Reason's model,[25] emphasize not holding professionals (individuals or teams) responsible for system failures, communication issues, or working conditions (e.g., fatigue, pressure, or overload) beyond their control (honest mistakes). At the same time, reckless behavior and negligence are not tolerated.[26–28] Honest mistakes may fit within the category of non-negligent minor imprudence.

IV. Consensual mechanisms should be established to differentiate honest mistakes (without intention) from intentional acts. The National Patient Safety Foundation proposed a logical, straightforward, and effective scheme in 2016 to distinguish between honest mistakes and unacceptable conduct, similar to Eurocontrol's proposal for introducing just culture principles in Europe (Regulation (EU) No 376/2014). Basically, after each incident, one can ask whether other members of the team or staff, with similar qualifications and training, would have done the same (substitution test) and whether the professional(s) were aware of violating preset standards (intention test). While the underlying logic of this proposal is easy to accept,[29] there are many situations where drawing a clear line between what is acceptable and what is not remains difficult. Experiences from other industries (e.g., Spain's State Program of Operational Safety for Civil Aviation, Law 1/2011 of March 4), No-Fault systems (e.g., New Zealand or Denmark), or mediation programs (CONAMED in Mexico or the experience in France) may serve as references for this analysis.

V. Healthcare professions experience high levels of stress and emotional involvement in their work.[30–33] During the COVID period, an unprecedented institutional response was mobilized to support the morale and workforce of this group, acknowledging their situation.[34] However, only 40% of countries have established a national program on occupational health and safety for healthcare workers, according to WHO recommendations.[35] The **second victim syndrome should be recognized as a workplace problem** and not solely a mental health issue. Feeling responsible for an unintentional error, worrying about a patient with a complicated course, or feeling that they have not done enough for a patient are all part of the emotional response of healthcare personnel. This experience limits responsiveness, decision-making, and practice. For instance, defensive practices increase when the environment is not conducive to a safety culture. Therefore, providing support to second victims contributes to increasing patient safety.[21]

VI. Programs that support second victims have a different approach when applied in countries with No-Fault systems, where there is no criminal intent [36] (e.g., RISE [37] programs in the US and BUDDY [38] in Denmark). These emotional support programs have started to expand with the inclusion of this objective in national patient safety strategies.[39] However, they currently face limitations due to the legal route that adverse events follow. The **design and conceptualization of these programs should be based on just culture principles**.[40,41]

VII. We need a **new regulatory framework** that provides legal guarantees that reporting an incident cannot lead to legal or disciplinary action, except in cases of clearly intentional conduct.[42] Similar legal privilege is needed for those who analyze the immediate and remote causes of safety incidents, collaborate in second victim support programs, or are involved in honest mistakes. This regulatory framework must not forget that citizens also require fair compensation (including knowing why the event occurred and what will be done to prevent recurrence) after a serious adverse event.[43]

Safety culture improves health outcomes, and as outcomes improve, the safety culture of healthcare institutions also improves.[44] In recent years, we have shifted from merely avoiding things going wrong to doing everything possible to ensure everything goes well.[45] There is no turning back, but certain changes are necessary for total credibility within the sector. Feelings of shame, fear of unforeseen consequences, or learning solely from experience after an adverse event should be definitively left behind if we want to overcome the prevailing attitudinal barriers and achieve the full engagement of healthcare professionals.

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