Patient Safety & Quality Improvement Journal
http://psj.mums.ac.ir
PSQI

The Role of a Safety Culture in Preventing Medical Errors

Farahzade Jabbari Azad

Professor of Allergy and Clinical Immunology, Mashhad University of Medical Sciences, Mashhad, Iran.
E-mail: jabbarifmums.ac.ir

ARTICLEINFO

Article type:
Editorial

ABSTRACT

Despite advancements in medical science and healthcare systems, preventable medical errors continue to cause significant harm globally. A growing body of evidence suggests that a strong organizational safety culture is essential to reducing such errors. This article discusses the defining features of safety culture, its impact on patient outcomes, and strategies to foster it within healthcare institutions. The authors argue that culture is not an add-on but a foundation for safe care.

Keywords: *Culture, Medical, Safety*

► ***Please cite this paper as:***
Jabbari Azad F. The Role of a Safety Culture in Preventing Medical Errors. Journal of Patient Safety and Quality Improvement. 2025; 13(2):87-88. Doi: 10.22038/psj.2025.89171.1474

Introduction

Medical errors are among the leading causes of avoidable morbidity and mortality in modern healthcare systems. According to estimates from the World Health Organization and national safety agencies, hundreds of thousands of patients are affected by preventable harm each year. Although technical and systemic improvements have contributed to error reduction, one critical and often under-addressed determinant remains: the safety culture of healthcare organizations. Safety culture refers to the shared values, beliefs, and behaviors that determine how safety is perceived, prioritized, and enacted within an institution. It is increasingly recognized not as a supplementary aspect of quality improvement, but as its very backbone. This article explores the essential role of safety culture in mitigating medical errors, with an emphasis on practical insights and recent evidence.

Discussion

Defining Safety Culture

A strong safety culture is characterized by openness, psychological safety, accountability without blame, and a commitment to continuous learning. It manifests in behaviors such as incident reporting, proactive identification of risks, and responsive leadership. Importantly, it is more than institutional slogans or accreditation metrics—it is the lived experience of clinicians, staff, and patients alike.

Safety Culture and Error Reduction

Several studies have demonstrated that hospitals with mature safety cultures report fewer adverse events, higher staff morale, and improved patient satisfaction (Singer et al., 2009; Weaver et al., 2013). For example, healthcare teams that encourage open reporting of near-misses are more likely to implement preemptive measures that prevent actual harm. In contrast, cultures that penalize error reporting contribute to silence and repetition of preventable mistakes.

From personal clinical experience and leadership observation, environments that embrace just culture principles show a remarkable resilience to stress and crisis. Even under high workload or uncertainty, these systems are more adaptive, transparent, and learning-oriented.

Challenges in Implementation

Despite its benefits, cultivating a safety culture is neither quick nor easy. Barriers include hierarchical structures, punitive attitudes, underreporting, and fragmented communication. Moreover, culture is not a static attribute; it requires ongoing reinforcement through leadership modeling, frontline engagement, patient partnership, and reliable feedback mechanisms. A noteworthy component is patient involvement. Patients and families often perceive subtle indicators of declining safety before clinical teams do. Their inclusion in safety planning is not only respectful—it is effective.

Conclusion

Improving safety in healthcare requires more than protocols and technology; it requires a cultural shift. Safety culture is not merely one strategy among many—it is the context in which all safety efforts either thrive or fail. A strong, transparent, and accountable culture can transform systems and save lives.

Leadership at all levels must prioritize culture-building as a continuous process. Clinicians must feel empowered to speak up. Institutions must move beyond compliance to commitment. Only then can we create systems where the prevention of harm is not the exception, but the norm.

References

1. Singer, S. J., Gaba, D. M., Geppert, J. J., Sinaiko, A. D., Howard, S. K., & Park, K. C. (2009). The culture of safety: results of an organization-wide survey in 15 California hospitals. Quality and Safety in Health Care, 18(5), 442–446.

2. Weaver, S. J., Lubomksi, L. H., Wilson, R. F., Pfoh, E. R., Martinez, K. A., & Dy, S. M. (2013). Promoting a culture of safety as a patient safety strategy: a systematic review. Annals of Internal Medicine, 158(5_Part_2), 369–374.

3. Sammer, C. E., Lykens, K., Singh, K. P., Mains, D. A., & Lackan, N. A. (2010). What is patient safety culture? A review of the literature. Journal of Nursing Scholarship, 42(2), 156–165.