Risk Management and Healthcare Policy

Dovepress
Taylor & Francis Group

PERSPECTIVES

Why Do We Fail at Reducing Medical Errors? Assuming Responsibility to Leverage Failure into Improvement

Mayer Brezis

Hadassah-Hebrew University Medical Center & Braun School of Public Health, Jerusalem, Israel

Correspondence: Mayer Brezis, Hebrew University of Jerusalem, Former Director of the Center for Clinical Quality & Safety, Hadassah Medical Center, Jerusalem, Israel, Tel +972-2-5619596, Email brezis@mail.huji.ac.il

Risk Management and Healthcare Policy downloaded from https://www.dovepress.com/ For personal use only.

Context: Medical errors are the third leading cause of death after heart disease and cancer, but in contrast to these conditions, progress in reducing mistakes has been minimal.

Personal Experience and Learning: I learned firsthand about barriers to improvement during events surrounding the death of my grandson, who had a complex heart defect missed on a pregnancy ultrasound. Following his tragedy, universal pulse oximetry screening was implemented at a national level, probably saving dozens of children from a similar fate every year in our country.

Barriers to Improvement: On the other hand, I also found a refusal to link failure with correction. Lawyers working for the HMO where ultrasound had missed the heart defect claimed that the practice was reasonable, rejecting responsibility for the failure and quest for improvement, such as considering adoption of AI for enhanced diagnostic accuracy. Pulse oximetry universal screening could have been implemented a decade ago (thereby preventing our tragedy). Still, the people in charge at a National Council then did not listen to the committee of experts they had appointed and who recommended the screening.

Insights: Linking errors with improvement brings meaning to suffering: the tragedy would not have been in vain if it had motivated corrective actions. Communication failure is responsible for most errors, and a significant barrier is the fear of speaking up. The lesson was tragically learned at NASA and other organizations, emphasizing the importance of listening to everyone to prevent disasters. Respectful listening is an essential key to cooperation and success.

Conclusion: Healthcare needs a paradigm shift to a culture of transparency, responsibility and collaboration, building growth from past failures, learning from mistakes to improve patient safety.

Keywords: medical errors, responsibility, accountability, transparency, speaking up, psychological safety, communication failure, listening, humility

Over the decades I spent teaching how to improve the quality of care, I never imagined that the most significant lesson I would learn would be from my grandson, Amit (see Figure 1), to whom I dedicate this essay.

Medical errors cause suffering and death on a scale approaching that of heart disease and cancer. In striking contrast to the remarkable progress in reducing mortality from these diseases over recent decades, attempts to reduce medical errors have largely failed,[1] suggesting the need for a systemic change.[2] I propose a framework for such a change in the following lines.

Following Amit's case and my appeal to the Ministry of Health, the Israeli Association for Neonatology introduced mandatory universal pulse oximetry screening for every newborn, as is the case in other countries, including the USA, where its introduction was associated with a 33% decrease in early infant mortality.[3] In tribute to a request by Amit's mother, the Association decided to name the screening after him and invited us to present his story at their annual conference. All hospitals adopted the screening, which is estimated to reduce the number of babies with undiagnosed critical heart defects from 76 to 31 each year (a figure expected to drop to 9 with AI-enhanced ultrasound[4]). Amit's

Received: 2 April 2025
Accepted: 4 October 2025
Published: 11 October 2025

© 2025 Brezis. This work is published and licensed by Dove Medical Press Limited. The full terms of this license are available at https://www.dovepress.com/terms.php and incorporate the Creative Commons Attribution – Non Commercial (unported, v4.0) License (http://creativecommons.org/licenses/by-nc/4.0/). By accessing the work you hereby accept the Terms. Non-commercial uses of the work are permitted without any further permission from Dove Medical Press Limited, provided the work is properly attributed. For permission for commercial use of this work, please see paragraphs 4.2 and 5 of our Terms (https://www.dovepress.com/terms.php).

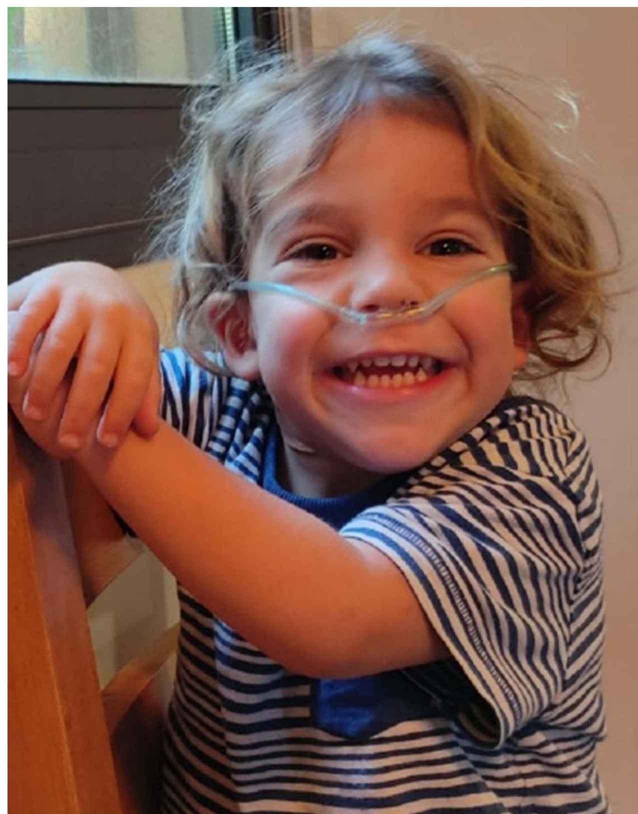

Figure 1 Amit Brezis 2018–2021. Amit was born with a complex heart defect discovered when he was one year old, as it was missed on a pregnancy ultra-sound and after birth. Due to this delay, surgery was complicated by severe pulmonary hypertension, need for ECMO and paraplegia. A year later, at the end of an elective catheterization, he again needed two hours of resuscitation, ECMO, and a month of intensive care, from which he recovered miraculously. Despite his handicap, he was a happy, curious, loving and loved child. Pulmonary hypertension persisted despite continuous O_2 and three medications (one by infusion pump). He died from a pulmonary hypertensive crisis at the entrance of Yom Kippur in 2021 when he was only three and a half years old.

tragedy was not in vain: drawing lessons from it probably saves dozens of children from a similar fate every year in our country.

Why cannot we more often and more systematically leverage failure into remediation?

Fear of liability is a significant barrier to developing patient safety initiatives. The fear of litigation creates a culture of secrecy and mistrust, which is still prevalent in healthcare institutions.[5] The events surrounding Amit's case gave me insights into those barriers, and I found evidence for a refusal to link failure with correction.

Legal and Institutional Barriers

A negligence claim provides compensation to a family that has been wrongfully injured. However, paradoxically, this line of action is an obstacle to correcting the system. To protect against legal liability, lawyers of an institution where a mistake occurred take the approach of denying the mistake and justifying the providers' actions; the "deny and defend" approach. Often, to shorten the legal process, the parties compromise with an agreement that releases the institution from responsibility for what happened and even prohibits the publication of the details. This silence prevents an opportunity to learn from mistakes, draw lessons, and make corrections.

Amit's parents filed a negligence claim against the HMO, where an ultrasound had missed the heart defect. The defense lawyers were quick to deny fault and say that the practice was reasonable (which is true: the sensitivity of pregnancy ultrasound to detect a heart defect is about 50%[4]). The parties finally agreed on a compromise with the payment of compensation and a clause exempting the institution from responsibility for what happened and precluding publication of the agreement's details.

I suggested including the following sentence in the compromise agreement: *The HMO will examine the feasibility of introducing artificial intelligence in ultrasound examinations during pregnancy to improve the chances of discovering heart defects in the fetus in the future*. I explained that any expression of a disposition for improvement would honor Amit's memory and provide meaning to his family's suffering: it would not have been in vain if it could reduce the risk in other children. The lawyers replied: "There is no way of including such a clause in the agreement because it would constitute an admission of responsibility for the failure." They also said that the agreement is with an insurance company that has nothing to do with HMO improvement activities. My attempts with HMO senior officials in charge of risk management did not help either. Their answer was adamant: one should not associate a tragedy with quality improvement. Instead of promoting the interest of the institution they represent to prevent similar glitches in the future, lawyers seem to declare: "It is convenient for us to continue making a living from defects in healthcare". In my opinion, refusing to include a clause about an intention for improvement is a slap in the face of current and future victims of the failure.

Systemic Secrecy

I wanted to know the extent of missed heart defects that had given grounds for lawsuits in Israel as a research question for a cost-utility analysis of AI in pregnancy ultrasound.[4] The four HMOs and the Ministry of Health refused to provide this information, making excuses such as that the information was not available or was confidential. A government insurance company also avoided answering. This systematic concealment not only makes a mockery of the freedom of information law, but it also indicates a desire to bury every piece of information from which we could learn about the extent of errors, as if it's better not to know, even though knowing the extent of errors is a significant step in accepting responsibility for correction. This approach insults victims' families as, for them, correction is part of healing.

Avoidance of Leveraging Mistakes into Improvement

I was surprised to discover the same refusal to link failure to learning at the Israel Medical Association (IMA). The decision to call the screening after Amit was rejected by the chairman of the Institute for Quality in Medicine at the IMA: according to him, calling a position paper after a patient constitutes a precedent with legal implications that prevail over the idea of creating a meaningful connection with Amit's story for the busy nurse who performs the screening in a hospital. Despite being a doctor, he was more cautious than his legal advisors at the IMA on the consequences of a link between failure and repair. He also seemed allergic to taking responsibility.

I believe doctors who strive for excellence want to lead a paradigm shift following a mistake by accepting responsibility, disclosing, and correcting the roots of the fault. Leading dozens of workshops with hundreds of senior officials in the health system, we found a consensus about transparency as the right policy.[6] Experience and research in Israel and worldwide have shown that telling the truth is the best defense after a mistake.[7]

Significance of Learning from a Family's Tragedy

Medical errors have long-term human consequences for families and providers at emotional, social and economic levels. A linkage between error and correction engrafts a meaning into the suffering; the tragedy leads us to strive to improve the system, bringing relief to victims. Healthcare needs a paradigm shift to a culture of transparency and responsibility, building growth from past failures.

Kintsugi is the Japanese art of repairing objects by joining fragments with gold (See Figure 2). It symbolizes a concept that shows beauty in flaws and the vital value of failures for growth. According to various thinkers, from Albert Camus[8] to Lord Jonathan Sachs,[9] a proper answer to the absurd in tragedies is to stand up for improvement, in Hebrew *Tikkun Olam* (literally "repair of the world"). This was the basis for the establishment of the State of Israel after the Holocaust. At an individual level, donating organs out of pain and brokenness gives life and hope. In the loss resulting from a mistake, to regain sanity, the task should be to prevent similar future failures: to turn one child's disaster into another child's survival.

Figure 2 A Broken Mug Restored with Kintsugi, a Japanese art of repairing objects with gold, symbolizing the value of failures. Picture courtesy of Ms. Keren Blumenthal.

Humility and Listening

In Israel, commemorating the fiftieth anniversary of the Yom Kippur War was accompanied by painful discussions: too few leaders accepted responsibility for failures before the war (that broke out, ironically, on the Day of Atonement). A former head of IDF Intelligence wrote about the "Egyptian deception and Israeli blindness", and warned that learning from error "must be an integral part of our culture – otherwise, we will be surprised again and caught off guard" in an article published on October 6, 2023.[10] The next day, a barbaric terror attack by Hamas killed, raped and/or kidnapped hundreds of civilians after repeated ominous warnings were ignored: we had again failed to learn from past failures.

A mistake can often be prevented by timely access to information unnoticed by the decision maker. In healthcare, communication failure within the team is responsible for most errors, and a significant barrier is the fear of speaking up: according to surveys in the USA and Israel, nearly a third of staff testified to fearing reporting something that could endanger a patient.[11,12] The difficulty of expressing oneself freely prevents the timely correction of failures and causes workers' burnout.[13] Improved communication relates to psychological safety in the organizational culture, ie, it occurs when the leader demonstrates humility, curiosity, and gratitude towards team members' opinions and ensures that no one gets hurt if they express an idea, question, concern, or report a mistake.[14–16] Training juniors and seniors by providing tools to improve communication within the team may be helpful and can be done through simulation-based workshops.[17–19]

The challenge of listening to prevent disasters was learned tragically at NASA. Commemorating the lost crews of the Columbia and Challenger shuttles, leaders emphasized the importance of learning from mistakes and the obligation to listen to everyone on the team to prevent a disaster: The most important thing is that we listen, that when we have a meeting, everybody feels free to speak up and air their concerns and that they're listened to and that we act on people's concerns, that we get all the right information when we're making our decisions.[20]

Listening requires doubting one's truth, a significant challenge when self-confidence grows with experience.[21] Humility could be a critical virtue for improving patient' safety.[22,23] In Israel, pulse oximetry universal screening could have been implemented a decade ago (thereby preventing Amit's tragedy), had the people in charge at a National Council only listened to the experts they had appointed and who recommended the screening based on firm scientific evidence already available.[24] Organizational learning is more essential than punishing those who made a mistake, which gives only an illusion that we have solved the problem: assuming responsibility can open the way to amendment, including a culture of listening to prevent mistakes. Respectful listening is essential to cooperation and success in society in general and healthcare organizations in particular.

The book *Being Wrong*[25] describes mistakes in various fields such as the legal system, science, and medicine, concluding that error is a basis for wisdom.[26] Far from being a sign of mental weakness or bad luck, making mistakes and learning from them is essential in human consciousness and growth. Recognizing our weaknesses is, in fact, a key to

Table 1 Practical Recommendations

Domain	Explanation	Examples of Tools
Conceptual thinking	Understanding the value of mistakes for system improvement	Literature resourcing with periodic demonstration by case studies at staff meetings
Leadership	Assuming responsibility for failure, disclosure of errors to families, and staff collaboration	Leading by example, promoting psychological safety
Education and Training	Teaching about learning from errors in healthcare professions, using simulation and real cases	Exercises in basic clinical and specialty training, testing skills and proficiency at licensing
Organizational learning	To implement a disclosure policy, the institution's director appoints teams to assist staff in meeting with patients and families following an error, with a debriefing to leadership	Designate and train rapid response teams to assist in real time. Video recording will allow periodic review for quality improvement of communication skills
Advocacy	Promoting a transparency culture throughout the organization	Collaboration with the institution's legal department, publication of case studies
Regulation	Facilitating transparency and assuming responsibility	Enforcing taking responsibility and disclosure in any compromise agreement

happiness and success.[27] According to the book *Black Box Thinking: Why Most People Never Learn from Their Mistakes–But Some Do*,[28] a crucial determinant of success is the willingness to engage failures, and the main challenge is conceptual rather than psychological or motivational:[28] Understanding that errors are key to progress. Medical errors will be reduced by recognizing the treasure inherent in errors and by assuming responsibility as leverage for improvement.

Practical Recommendations

Table 1 lists practical recommendations for implementing the issues mentioned in the above discussion.

Conclusion

Healthcare needs a paradigm shift to a culture of transparency, responsibility and collaboration, building growth from past failures, learning from mistakes to improve patient safety. This will require conceptual understanding of the value of mistakes, leadership, education and training, organizational learning, advocacy, and regulation.

Consent for Publication

Amit's parents provided written informed consent to publish his picture and clinical details.

Disclosure

The author reports no conflicts of interest in this work.

References

1. Bates DW, Levine DM, Salmasian H, et al. The safety of inpatient health care. *N Engl J Med*. 2023;388(2):142–153. doi:10.1056/NEJMsa2206117
2. Berwick Donald M. Constancy of purpose for improving patient safety — missing in action. *N Engl J Med*. 2023;388(2):181–182. doi:10.1056/NEJMe2213567
3. Abouk R, Grosse SD, Ailes EC, Oster ME. Association of US state implementation of newborn screening policies for critical congenital heart disease with early infant cardiac deaths. *JAMA*. 2017;318(21):2111–2118. doi:10.1001/jama.2017.17627
4. Ginsberg GM, Drukker L, Pollak U, Brezis M. Cost-utility analysis of prenatal diagnosis of congenital cardiac diseases using deep learning. *Cost Eff Resour Allocation*. 2024;22(1):44. doi:10.1186/s12962-024-00550-3
5. Perez B, Knych SA, Weaver SJ, et al. Understanding the barriers to physician error reporting and disclosure: a systemic approach to a systemic problem. *J Patient Safety*. 2014;10(1):45–51. doi:10.1097/PTS.0b013e31829e4b68
6. Finkelstein A, Brezis M, Taub A, Arad D. Disclosure following a medical error: lessons learned from a national initiative of workshops with patients, healthcare teams, and executives. *Israel J Health Policy Res*. 2024;13(1):13. doi:10.1186/s13584-024-00599-8

7. Gallagher TH, Mello MM, Sage WM, Bell SK, McDonald TB, Thomas EJ. Can communication-and-resolution programs achieve their potential? Five key questions. *Health Aff*. 2018;37(11):1845–1852. doi:10.1377/hlthaff.2018.0727
8. Sagi A. Albert Camus and the philosophy of the absurd. In: *Value Inquiry Book Series v 125*. Vol. vi. 1st. Rodopi; 2002:193.
9. Sacks RJ. Mending the World. *Jewish Political Stud Rev*. 2013;25(3/4):108–118.
10. General (Res.) Farkache AZ. The Egyptian deception and the Israeli blindness. *Yedioth (in Hebrew)*. 2023. https://www.ynet.co.il/yedioth/article/yokra13618196.
11. Martinez W, Lehmann LS, Thomas EJ, et al. Speaking up about traditional and professionalism-related patient safety threats: a national survey of interns and residents. *BMJ Qual Saf*. 2017;26(11):869–880. doi:10.1136/bmjqs-2016-006284
12. Okuyama A, Wagner C, Bijnen B. Speaking up for patient safety by hospital-based health care professionals: a literature review. *BMC Health Serv Res*. 2014;14(1):61. doi:10.1186/1472-6963-14-61
13. Dean W, Talbot SG, Caplan A. Clarifying the language of clinician distress. *JAMA*. 2020;323(10):923–924. doi:10.1001/jama.2019.21576
14. Grailey KE, Murray E, Reader T, Brett SJ. The presence and potential impact of psychological safety in the healthcare setting: an evidence synthesis. *BMC Health Serv Res*. 2021;21(1):773. doi:10.1186/s12913-021-06740-6
15. Kane J, Munn L, Kane SF, Srulovici E. Defining speaking up in the healthcare system: a systematic review. *J Gen Intern Med*. 2023;1–8.
16. Wawersik D, Palaganas J. Organizational factors that promote error reporting in healthcare: a scoping review. *J Healthc Manag*. 2022;67(4).
17. Chen H-W, Wu J-C, Kang Y-N, Chiu Y-J, Hu SH. Assertive communication training for nurses to speak up in cases of medical errors: a systematic review and meta-analysis. *Nurse Educ Today*. 2023;126:105831. doi:10.1016/j.nedt.2023.105831
18. Lee E, De Gagne JC, Randall PS, Kim H, Tuttle B. Effectiveness of speak-up training programs for clinical nurses: a scoping review. *Int J Nurs Stud*. 2022;136:104375. doi:10.1016/j.ijnurstu.2022.104375
19. O'Connor P, Byrne D, O'Dea A, McVeigh TP, Kerin MJ. "Excuse Me:" Teaching Interns to Speak Up. *Joint Comm J Quality Patient Safety*. 2013;39(9):426–431. doi:10.1016/S1553-7250(13)39056-4
20. Speck E. 20 years after Columbia NASA remembers astronauts lost, vows not to repeat past mistakes of human spaceflight. *FOX Weather*. 2023. Available from: https://www.foxweather.com/earth-space/nasa-remembers-astronauts-lost-vows-to-not-repeat-past-mistakes-of-human-spaceflight. Accessed October 7, 2025.
21. Brezis M, Orkin-Bedolach Y, Fink D, Kiderman A. Does physician's training induce overconfidence that hampers disclosing errors? *J Patient Safety*. 2019;15(4):296–298. doi:10.1097/PTS.0000000000000255
22. Lehmann M, Pery S, Kluger AN, Hekman DR, Owens BP, Malloy TE. Relationship-specific (dyadic) humility: how your humility predicts my psychological safety and performance. *J Appl Psychol*. 2023;108(5):809–825. doi:10.1037/apl0001059
23. Matchett CL, Usher EL, Ratelle JT, et al. Physician humility: a review and call to revive virtue in medicine. *Ann Intern Med*. 2024;177(9):1251–1258. doi:10.7326/M24-0842
24. Bin-Nun A, Hammerman C, Mimouni FB, Wasserteil N, Kasirer YM. The saga of pulse oximetry screening for critical congenital heart disease in israel: a historical perspective. *Isr Med Assoc J*. 2021;23(4):229–232. and summary report of the National Council for Pediatrics & Child Health to the Director General of the Ministry of Health (document # 00203114, January 21, 2014).
25. Schulz K. *Being Wrong: Adventures in the Margin of Error*. 1st Vol. viii. Ecco;2010.405.
26. Schulz K. On being wrong. TED conference. 2011. Available from: https://www.ted.com/talks/kathryn_schulz_on_being_wrong.
27. Brown B. The power of vulnerability. TED conference. 2010. Available from: https://www.ted.com/talks/brene_brown_the_power_of_vulnerability?subtitle=en. Accessed October 7, 2025.
28. Syed M. *Black Box Thinking: Why Most People Never Learn From Their Mistakes–But Some Do*. Penguin; 2015.

Risk Management and Healthcare Policy

Dovepress
Taylor & Francis Group

Publish your work in this journal

Risk Management and Healthcare Policy is an international, peer-reviewed, open access journal focusing on all aspects of public health, policy, and preventative measures to promote good health and improve morbidity and mortality in the population. The journal welcomes submitted papers covering original research, basic science, clinical & epidemiological studies, reviews and evaluations, guidelines, expert opinion and commentary, case reports and extended reports. The manuscript management system is completely online and includes a very quick and fair peer-review system, which is all easy to use. Visit http://www.dovepress.com/testimonials.php to read real quotes from published authors.

Submit your manuscript here: https://www.dovepress.com/risk-management-and-healthcare-policy-journal