

Failure Is the New Success

INTRODUCTION

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FORTY IS THE new thirty. Orange is the new black. And failure is the new success.

These days, it seems that no success story is complete without a failure (or two) along the way – the bankruptcy that gave birth to a successful company or the entrepreneur who lost it all just before hitting the Fortune 500. Entire issues of the *Harvard Business Review* and *The New York Times Magazine* have been devoted to failure. In the business world, leaders are told, “Fail fast, fail early, fail often.”

In many sectors, it is understood that to innovate, we must accept – even celebrate – failure. Many sectors willingly “launch a thousand ships,” knowing that only a small number will reach the distant shore.

Healthcare needs positive innovation. At nearly 12% of our GDP, healthcare is

a huge part of the Canadian economy and one in which new ways of doing business are needed. Yet as an industry, it has not been accepted that part of improvement must be a willingness to fail.

Thus when we fail in healthcare we often double fail – once in the event and again when we are unable to recognize, name and learn from that failure.

This issue is part of the ongoing work of health system leaders and academics to stop that double failure. We need to identify, name and learn from system failures.

This is not an issue focused on mistakes (errors). Mistakes are actions and judgments that are wrong or repeated failures (Godin 2015). Our focus here is not on how healthcare systems should minimize mistakes

but rather on how these systems should be structured so that we learn from the inevitable failures that come with trying new ways of delivering care.

Not all failure is that kind of “good failure.” Failure due to deviance from a proven path, inattention or lack of individual preparation is not what we should aim to celebrate (Edmonson 2011). It is in the world of uncertainty, and the testing of hypotheses about how to do better, that the kind of failure we seek to encourage resides.

We have also worked hard in this issue to keep the focus away from failures at the level of the individual patient or provider, or even at the organizational level. Important progress has been made and will continue to be made in these areas. Much of the burgeoning field of quality improvement is about learning from failures at the coalface of clinical care. We have come a long way from the culture of “blame and shame” that once existed in healthcare and emerged into a world of root-cause analysis, system reorientation, surgical safety checklists and provider-level audit and feedback.

It is at the level of healthcare systems where progress needs to be made.

In this issue, our lead author and respondents have grappled with questions at the system level. How can we build healthcare systems that identify, name and learn from failure? How can we move from a world in which failed system-level experimentation brings the Auditor General to the doorstep, the Opposition to its feet in question period and stories of waste to the front page? What would a system that uses public dollars responsibly yet is allowed to take risks look like?

The time to answer these questions is now. Canadian medicare is under unprecedented pressure. Our society, like many others, faces an aging population. The pace

of technology is accelerating. The expectations of the public steadily shift. And a system built around physicians, hospitals and acutely ill patients is not the answer to our challenges.

As we move to redesign healthcare delivery to meet the changing needs of the Canadian public, we need to be prepared for some hard knocks. One of the reasons why we can expect to fail is that healthcare systems are complex and non-linear systems. There is no checklist to prevent failure in complex systems. It is in fact this complexity that Zwarenstein, in his lead article, argues should “nudge us in the direction of being more systematic about how we innovate in healthcare ...” but instead “... we have tended to hide our failures, even from ourselves” (Zwarenstein 2015).

The goal of this issue is not to lay out a path to prevent failure but rather to encourage, anticipate and ultimately learn from it. If success is inspiring, failure should be enlightening, as Daub (2015) points out in her commentary.

In healthcare, we often talk about learning from other industries. Bhattacharyya and Bhatia (2015) note that healthcare “has already learned a great deal from the manufacturing industry about quality control, process optimization and small tests of change.” It is also certainly true that other sectors have a more developed approach to dealing with, even celebrating, failure. But healthcare is not venture capitalism. Some risks are not appropriate to take in a publicly funded system, where lives are on the line. So we need to learn what we can from other industries without falling into the trap of thinking that they “have it all figured out.”

In these papers, we turn from evolution to gardening to the software industry. We learn about academic frameworks for failure and real-life healthcare trials like Toronto’s virtual ward.

Most of all, we hear from a remarkably broad number of people about the need to stop failing twice. Ikura et al. (2015) speak to the economic and time costs but also of the lost goodwill of patients and taxpayers who want our system to steadily improve.

From a variety of perspectives and rationales, the authors in this issue achieve a shared consensus on the urgent need to embrace failure at the system level. They then offer a range of approaches for how we might do so. Key ideas include setting explicit goals *a priori* when experimenting with health services delivery so that success and failure can be clearly labelled. Evaluation should take place early and often, with a view to incremental and data-driven shifts in approach. Failure is then less a sudden, unexpected end point following several years of program rollout but an early, easily identified opportunity for change. We should structure our reviews not just with a view to outcomes but looking at the “how” of our work, to see what processes inform outcomes. Once failure is identified, we need to be better at “removing what we don’t want” (Daub 2015).

As with most significant changes, adopting an approach of learning from failure needs to include leadership that demonstrates an approach to talking about failure. Leaders include those at the front line of change initiatives as well as the funders behind a project. Leaders should be held to account and should have the flexibility to accept, and in fact be encouraging of, “good failure.”

The breadth of options suggested for learning from failure offers organizations and systems choice. Likely a number of approaches are needed. However, the diversity of suggestions in these pages may also speak to a lack of knowledge about which techniques in healthcare might work best.

Over time, with exploration and analysis, we will collectively learn which approaches help us learn from failure and which do not. We will have, as we should, failure in our efforts to learn from failure.

In an industry as large and complex as healthcare, where innovation is a must, we are bound to make errors. But it’s the double-failure that we should worry about – the inability to name and learn from our failures so that we can do better. The “we” is broad, as noted by Lewis (2015). “All of us – providers, policymakers, governments, citizens and patients – are implicated. We are all complicit in the failure to deal with failure ...”. Failure may be the new success in some industries, but to date in healthcare, it’s still just failure.

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