

Failure in Residency Education: Lessons Learned From Harry Potter, Oprah Winfrey, and the Marigold Hotel

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What do J.K. Rowling, Thomas Edison, Oprah Winfrey, and Colonel Sanders have in common?¹

They all failed. Not in a superficial “bad day” way, but in a career-threatening, atomic meltdown way. They failed utterly and completely.

J.K. Rowling, author of the *Harry Potter* series, was “as poor as one could be in Britain without being homeless.”² She was a single mother, jobless, on government assistance, scratching out the tales of a young student wizard. All 12 major British publishers rejected the first *Harry Potter* book.

Thomas Edison was told by teachers that he was “too stupid to learn anything.” He dropped out of school and was educated by his mother. He was also fired from his first 2 jobs for not being productive enough.

Oprah Winfrey was fired from her first job as a local television news correspondent because she was “unfit for television.”

Colonel Sanders peddled his proprietary chicken recipe to more than 1000 restaurants over more than 12 years. He was 62 years old when the first Kentucky Fried Chicken restaurant opened.

If they had stopped amid their failure, what then? We would never have befriended an orphaned wizard. Someone else would have invented the light bulb. There would be a strange gap in daytime television. The phrase, “finger lickin’ good,” would have no meaning.

For every *Harry Potter* there are thousands of unpublished novels. Not every local television correspondent or rookie telegraph operator gets a second chance. Millions of restaurateurs have lost their savings despite the greatest recipes of all time. We remember Rowling, Edison, Winfrey, and the Colonel because they succeeded. They failed, but they failed well. They persevered.

In medicine, I believe that we do not fail well. Perhaps the stakes are too high. Patients can be harmed by our errors. We bury our mistakes—literally and figuratively. The fearful scent of lawsuits

is ever in the air. Only among trusted colleagues in hushed tones—if at all—do we speak of our mistakes or whether we have been named in a lawsuit. And yet, being named in a lawsuit is quite common.³ By the age of 65, 19% of physicians in low-risk specialties and 71% of physicians in high-risk specialties have made indemnity payments. Sometimes the physician committed an error, sometimes not. Many of us fail the boards. Ninety percent of first-time test takers pass the internal medicine boards—which means 10% fail.⁴ The pass rate for the general surgery certifying examination is only 79%.⁵

Failure is endemic to our medical culture, and yet so rarely discussed. Is it our ego? Is it fear of humiliation? In the medical education world, failure is practically a professional colleague. We encounter failure regularly on rounds and in the clinics. Our residents are on the edge of their comfort zone, always stretching to a new skill, working to their limits and growing past them. Hopefully, they do this in a supportive, structured environment that emphasizes patient safety. And yet, residency training is an exercise in processing failure. Most of our failures usually involve our egos—feeling we were late with a diagnosis, not appearing smart enough in morning report—and never harm the patient. And so, we guard these little failures like a secret.

In my years as a residency program director, I believe that we do not fail well because we do not forgive well. We are slow to acknowledge our faults because we do not believe in redemption. We have a thin culture of reconciliation. Perhaps the closest moment in the hospital is morbidity and mortality rounds, where errors are discussed candidly within a protocol of confidentiality. There was the patient misdiagnosed as septic shock from a urinary tract infection—and actually had an aortic dissection. There was the patient with the overlooked opacity in the liver that was later diagnosed as metastatic disease. We seek to evaluate the root cause of errors without assigning personal blame. While candid assessment leads a team to understand medical error, this process is usually devoid of personal or communal reconciliation. How do we create a culture of

redemption? How do we create a safe space to fail? I wonder if we have a knowledge-driven culture, but not a kindness-driven culture. We are quick to judge, and slow to forgive.

Failure is not only a professional crisis, but also an existential crisis that destabilizes our sense of meaning and value as physicians. In 1952, Paul Tillich wrote *The Courage to Be*. He was a public intellectual in the truest sense—a professor at Harvard University, which allowed him to teach across faculties. He also made the cover of *Time* magazine.⁶ He describes the heady times of post-WWII American culture. We had rescued the free world and now entered an era of prosperity. However, beneath it all lurks what Tillich describes as an “anxiety of meaninglessness,”⁷ where our material prosperity and political stability is not enough. Does this not describe aspects of our medical culture with our polished degrees and fresh-pressed white coats that cover our disquiet? He writes further, “the courage to be is the courage to accept oneself, in spite of being unacceptable.”⁷ By “being unacceptable,” I believe he means that we must reconcile ourselves to our faults and imperfections—and accepting our faults requires courage and moral strength.

This idea of courage and acceptance is exemplified in the art house film *The Best Exotic Marigold Hotel*, which tells of 7 British expatriates who retire to India. They find themselves in a dilapidated hotel, not quite what the brochure promised, but managed by Sonny, an earnest, young hotelier. To a disgruntled expatriate who threatens to leave, Sonny proclaims, “Everything will be all right in the end. If it’s not all right, it’s not yet the end.”⁸ This line serves us well in medical education. Sonny puts an optimistic interpretation to Tillich’s call for courage. In the same movie, Evelyn, a grieving widow played by Judi Dench, says, “The only real failure is the failure to try . . . The person who risks nothing, does nothing, has nothing.”⁹ Medicine is hard. Medicine is risky. Failure is part of the landscape. Is it too much to ask for a program director to address existential angst? I believe this is precisely what we are called to do. Who else but us? We must extend the reconciliation that is our hope and model the courage and kindness we seek in our

culture. We must be at least as generous and hospitable as the proprietor of the Marigold Hotel.

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