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STRATEGY OF LEARNING FROM MISTAKES

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Summary: *Learning, i.e. the acquisition of knowledge, skills and abilities is one of the key elements in the management of modern organizations. Many people get college degrees or build a career with the most important places in the organization, and yet they have not learned how to learn. Indeed, we can learn everywhere, any place and any time. One can learn from animals, from other people, from their own experiences, at universities. Each of these modes of learning has its own characteristics. Common to all concepts of learning is that they are more or less known and largely standardized. However, learning from mistakes is completely neglected, especially strategies that provide an answer to the question of how to learn from mistakes and how to turn negative sides of errors into benefits for both individuals and companies. The reason for the above largely lies in the indisputable fact that few people are willing to admit a mistake and learn certain lessons as a kind of knowledge that can be acquired through experience and work. In other words, no one wants to have witnesses when he makes mistakes; further, very few people are willing to remember their mistakes or return to the analysis of errors they had made. Because of the above, this issue is largely unknown in the management theory.*
This paper deals with strategies for learning from errors perceived in a new context, i.e. the paper deals with the fact that errors are a good thing provided that individuals or organizations can learn from them. This corresponds to modern conditions, where there is great complexity and interdependence of business, and thus there are greater chances of errors and omissions.

Keywords*: strategy, learning, errors*

1. ERRORS IN MODERN BUSINESS CONTEXT

The old folk wisdom says: 'To err is human'. This proverb is more or less familiar to everyone, but what we do not know is just how to explain this to the boss. Indeed, mistakes are an integral part of life and work of every man. However, most people, especially managers are not willing to tolerate errors. Managers are especially not ready to tolerate errors that are repeated by individuals and are results of lack of dedication. In these circumstances, huge managing energy is spent on finding and sanctioning the 'guilty' ones or to disguise and conceal errors or omissions.
Modern management is trying to point out to employees that mistakes are indeed not disasters, and that they are allowed if they are made in good faith, or if the error arose

from efforts aimed at initiative and creativity. The effect of this attitude lies in the creation, dissemination and implementation of new ideas or improving business, which is often far greater effect than the damage from errors that occur in organizations. We need to add another alpha plus, and it is that we can learn from mistakes and much more so than we can learn from success. This statement is natural, because mistakes are all around us and evident to all of us. The greatest effect is achieved if one learns from the mistakes of others. To what extent this way of learning is currently available can be seen from case studies, where at famous business colleges there are no classic lessons given, but students analyze the faults of famous names from the world of business, so that in the future the errors would not be repeated. It turns out that mistakes and their analysis are important things from which organizations can determine the reasons for failure. Research and practice show that business leaders usually make the next seven deadly mistakes:[1]

- Too ambitious (unrealistic) goals,
- Formulation of vague and immeasurable (generalized) goals,
  Neglect of planning in the realization of objectives,
- Fear of leaders and overburdened staff,
- Undefined personal responsibility for the implementation of key objectives,
- Search for objective reasons to justify the failure,
- Conditioning on the part of the perpetrator,

It is evident that out of 7 deadly mistakes of leaders three of them are related to the phenomenon of goals. Overambitious goals are actually unrealistic, since capabilities and potentials of organizations are often being compared to each other. If it is determined that there is a gap between the target and the capacity of the organization, it can be very discouraging for employees. Therefore, wise managers must be realistic, because the low-set goals can also be a problem, especially in conditions of high turbulence, when seeking adequate dynamism. The same applies to formulation of vague and immeasurable (generalized) goals. Practice has shown that generalized goals are a huge problem which is why every single goal should be made measurable. It is clear that every business can be measured, as well as jobs in research or intellectual organizations.

If in the above context mistakes are indeed allowed but should not be repeated, we then face the question of how to treat those who keep making mistakes in their business activities? It is certain that management must not turn into a 'hunter' of errors, nor should it point to sinners to often for both errors and sanctions can only rectify the past and it is future that is necessary for organizations. Sanctioning, i.e. frequent punishment of individuals is not the solution to this problem, because every action of management shall result in reaction. Over time, individuals get used to sanctions and show lack of will to change their attitude towards jobs and work tasks.

It seems that in the above situation manager should point out the problem to the 'sinner' in a friendly, informal atmosphere. Formal conversations, i.e. communication that takes place in the general manager's office should be avoided; we should especially avoid communication on the superior-subordinate level. Research performed by the Managers Edge at the beginning of the new millennium has shown that manager's behavior is very important for the success of this communication. When entering subordinate's office, superior should do as follows: sit down, speak in private, and make that conversation friendly and benevolent. Comparison to the field of medicine could be useful here. When a doctor in the course of his visit takes a sit at patient's bed and speak in private with his patient,

the patient then feel as if the doctor had given them much more time then usually, when he simply remained standing beside the bed. Practice shows that it is effective when the group indicates the fault of individuals. Nevertheless, in order for this technique to be effective it is necessary that the organization or the group be prepared, i.e. educated for this type of problem solutions. The leader of the company has a major role here, especially if in his work he implements intelligent ways of eliminating or marginalizing errors, such as: getting people to accept ideas of management, external training, acceptance of 'sinners' into creation of certain rules of behavior aimed at reducing the number of errors.
Individuals that keep repeating mistakes could be subjected to monetary, disciplinary, ethical and other types of sanctions, including dismissal from work. Research conducted by the Disability Management Employer Coalition has shown that punishing people is not the best way to prevent mistakes, but it is much better when we reward those who do not repeat mistakes. [2] Therefore, sanctioning should be the very last course of action, and, as a rule, it should be undertaken only when all the other measures and mechanisms have been used to the full. It has been shown that dismissals create new enemies for the organization; further, this action is highly unpleasant for management as well. It is, thus, of ultimate importance to check personnel before they get hired, in the selection phase, especially from the point of view of their adaptability and readiness to observe technological regime of the organization and to behave responsibly in regard to his job and business as a whole.

2. THE STRATEGY OF LEARNING FROM MISTAKES

It has already been noted that errors must not be repeated, and that mistakes can be useful especially if something is learned from them, both by individuals and organizations. In order to learn something from mistakes it is first necessary for us to admit that a mistake has happened; then we have to make it transparent. Errors that are not transparent are not a base for functional learning. Therefore, it is necessary to establish personal responsibility for errors, especially when it comes to crucial mistakes, because without absence of this mechanism increases entropy in the functioning of the organization.
Significant results in strategic management organizations have been achieved by the intelligent business strategy that includes business improvement through the use of information systems in strategic, as well as operative and tactical decisions. Therefore, it is a strategy that has a direct impact on business performance and includes: collecting and analyzing internal and external data, scheduling, business process analysis, analysis of customers and suppliers, financial development, market trends and competition, analysis of legislation and its impact on business, quality control, etc.[3]
Practice suggests different strategies for learning from mistakes and for handling different effects they produce. However, all strategies are based on the following three core activities, which stand in causal connections and relationships, namely: (1) detection, (2) analyzing and (3) experiment.

2.1. Dettection of errors

Spotting large, painful and costly mistakes is easy, although there is tendency to keep them secret as long as possible. However, practice shows that in any organization errors can remain hidden only until they cause immediate or apparent damage, or until became obvious. Therefore, the overall goal is to spot the mistakes as soon as possible, i.e. before

they grow into a real disaster. In this context, the management is enabled - based on appropriate symptoms – to diagnose retrograde phenomena in the organization and prescribe adequate therapy, or "drugs".
Shortly after he arrived from Boeing to take a job at Ford, in September 2006, Alan Mula established a new system of debugging. He asked the managers to mark good reports green, warning yellow, and to mark the problematic statements red, which is a common technique of management. According to a story from 2009 (Fortune), during the first meetings all managers had marked their operations green, which particularly annoyed Mula. Reminding them that the company lost several billion dollars last year, he asked directly: "Isn't there something that might not work well?" After one temporary yellow report was submitted in connection with a serious defect in the product which would certainly retained the launch of products, Mule responded to a dead silence followed by applause. After that, the weekly staff meetings were full of colors. [4]
Managers use a number of various techniques for detecting errors. Still, most of those techniques are not used in an adequate way. After errors are detected through these techniques, managers then fail to forward the results to other parts of the organization in order for them to learn so that the same errors would not be repeated in other organizational parts. For example, the Electricity of France, which operates 58 nuclear power plants, is a true exemplar in this area. The management of this giant goes beyond the regular requirements; they devoutly follow each plant in relation to everything that might be in the least unusual; then they immediately investigate everything that happens and inform all other plants of any eventual anomalies in the work.
Within detection of errors there is a widespread behavior of reluctance to convey bad news to higher levels, or to portray the situation brighter than it actually is, or to put blame for errors onto other entities, or objective circumstances. This is because of personal interest of various directors as their continued position might become questionable. Therefore, stakeholders and other interested groups frequently check the veracity of reports by special bodies or agents, and even through personal insight during ordinary and extraordinary control.
However, management should change their approach in this regard and encourage employees to recognize the errors and admit where they were wrong. Stubbornness on this issue can be fatal, and often paid in human heads. In this context, certain managers organize the 'failure parties' in honor of intelligent, high - quality scientific experiments that did not achieve the desired results. These parties do not cost a lot of money; diverting valuable sources - especially scientists - on new projects as soon as possible, can save you thousands of dollars, not to mention encouraging potential new discoveries.

2.2 Analyzing errors

When an error is detected, it is essential to determine the cause or source of error. It is assumed that each occurrence of the process have their causes that lead to positive and negative results. Hence the need for discipline (and enthusiasm) to implement sophisticated analysis; the aim is to establish the right diagnosis as the basis for elimination of errors. It is the duty of management to ensure that the organization, after detecting errors, more decisively move forward and take measures that these or similar mistakes are not repeated.
Practice shows that the error analysis is often superficial and often accompanied by a high level of subjectivity. It turns out that the examination of errors or reference to personal

mistakes is deeply emotionally uncomfortable and can undermine self-confidence. Left to themselves, most people review in a cursory way or try to completely avoid the analysis of errors. Another reason is that analysis of organizational failures requires research and openness, patience and tolerance for occasional ambiguity. However, managers generally admire and get rewarded for decisiveness, efficiency and activity - and not for the careful thought. Therefore, the building of organizational culture and behaviors is an essential thing for a successful analysis of errors, because it is one way of teaching people and organizations.

The key to successful analysis of errors lies in the documentation basis of mistakes at the level of the whole organization. The level of this documentation may be different, from the observation of business processes, logging, to creation of certain special documents. 'Without documentation, we do not know where we went wrong,' says Frank Bettger. 'It is more useful for me to analyze my own documentation then anything I can read in a magazine. Clay Hamlin, one of the largest retailers in the world, often gave me good ideas. He told me that as a seller he had failed three times because he did not keep records. When he corrected this error, i.e. introduced documentation, there were no more errors and failures.[5]

The research practices of functioning of complex organizations such as hospitals, where human lives "hang" by a thin string, show that the error analysis is rarely performed, or that they are inefficient. Only a small number of hospitals systematically analyze medical errors or poorly implemented procedures in order to learn something. A recent survey in the hospitals of North Carolina, published in November 2010, in the New England Journal of Medicine, showed that, despite the longtime increased awareness that medical errors result in loss of thousands of lives each year, the hospitals did not feel any safer. Medical specialists in many cases are not willing to jeopardize their colleagues' procedure that led to the error, even in complex trials. Therefore, in addition to the organizational culture it is necessary to develop ethics as well. In this specific case it is medical ethics, in order to change the attitude towards mistakes.

Fortunately, there are certain bright examples of exceptions to this model, which continue to give hope that organizational learning is indeed possible. In Intermountain health care system used by 23 hospitals in Utah and southeastern Idaho, deviations from medical protocols are routinely analyzed to investigate the possibility of improving procedures. Both license to deviate from the protocol and exchange data with the aim of obtaining better outcomes encourage doctors to be involved in this program.[6]

2.3. Promoting experiments

The third critical activity of effective teaching is a strategic manufacturing of errors - in the right place at the right time - through systematic experimentation. The scientists who perform experiments in basic sciences know that although conducted experiments sometimes give spectacular results, a high percentage of them (70% or more) fail. How do these people get up from their beds in the morning after such failure? First, they know that failure often occurs in their work; it is an integral part of the enterprise where you are within easy reach of scientific discovery. Second, they, to a much greater extent than most of us, realize that every failure carries valuable information and they are anxious to get to the information before the competition.

In contrast, managers who are in charge of trying out a new product or service - a classic example of an experiment in business - generally keep doing everything in their power to

prove that the pilot product or service is perfect, from the very start. Ironically, hunger for success can later prevent success of official products. Too often, managers of pilot products design optimal conditions rather than representative conditions. In this way the pilot will fail to show you what it is that does not work.
Analysis of business practice shows that successful organizations are those that do have a system for detecting and analyzing errors and to motivate employees to indicate the error. We must develop systemic "insider system" in which individuals report errors, knowing that their good intentions will not be misused. In particular, we should stimulate the creation of intelligent fault that is to be used for the purpose of learning and the creation of new products, processes or technologies. It turns out that managers who foster a culture of intelligent fault, considered the same as a side product of experimentation and improvement of business. They also realize that one does not have to make big experiments that require a high budget. Sometimes it is enough to have a small pilot, piloting techniques, "dry" simulations; they can all give adequate results. Of course, one should make a profit through gradual improvements, or by turning a small idea into a functional improvement of products and services, while fundamental improvements are associated with the scientific and similar organizations. Everything indicates that learning from mistakes will help strategies necessary to develop a strategy that will provide the answer to the question of how to design the organization in diverse operating conditions.[7]

3. RESUME

Previous analysis has shown that errors must be managed efficiently, because inadequate response to errors by employees can lead to a situation of relaxation that inevitably leads to irresponsibility of certain act, or omission in organizations. On the other hand, too much attention to mistakes can block a huge intellectual potential and creativity that exists in people, because if people are afraid of mistakes and have a feeling that even for beneficial bugs they shall be punished, they will avoid experimenting and look for more efficient ways of doing things. In this case, the organization will not prosper, but lag behind. Therefore, it is necessary to get rid of the old cultural beliefs and stereotyped perceptions of success and embrace a strategy that claims that the biggest mistake is prohibit the right to make mistakes.
Strategic management must diagnosed types of errors and their causes. Mistakes are sometimes wrong, often unavoidable, but in other situations and contexts they could be very good and helpful. Professional management strives to learn from mistakes, in order for them not to happen again. In order to successfully learn from mistakes, it is necessary to build a strategy of learning from the mistakes arising from the strategy of the company. In other words, there can be no strategy of learning from mistakes unless we have the strategy at the level of the whole, which imposes the need to observe this phenomenon from the perspective of holism.
Learning from mistakes is implemented through three main activities: detection, analysis and experimentation. Detection and identification of large, painful and costly errors is relatively easy. The most important thing is to spot these errors as early as possible, before it comes to a lot of damage. Analyzing errors is aimed at determination of the causes of errors and drawing certain conclusions or lessons. Promoting experimentation is a strategic manufacturing of errors - in the right place at the right time - through systematic experimentation; as a rule, they are useful in a wider context.

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