

Systems Have Their Place: **SECOND** Place

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There is no doubt whatsoever about the importance of systems—even in a 1-person business. For most of us, the “to do” list—a system if ever there were one—is an imperative aid to making it through the day. On the other hand, there is an other hand. That “to do” list is worthless without the will and discipline to follow up with execution—i.e., actually doing the “to dos.” And if that execution and doing involves others’ help, as it usually does, then our attitude will differentiate between success and failure.

Fact is, we could get by without the system—the “to do” list per se. But we could not get by or get anything done without the culture—the discipline to follow up and attitude required to effectively work with others.

*Hence, the title of this paper: “Systems Have Their Place: **SECOND** Place.” Herein are 10 cases—from the U.S. Air Force to Mayo Clinic to Toyota—in which systems, though of the utmost importance, were toothless without the “right” “organizational culture” to abet performance excellence.*

Systems Have Their Place: SECOND Place

“With ISO 9000 [quality standards] you can still have terrible products. You can certify a manufacturer that makes life jackets from concrete, as long as those jackets are made according to the documented procedures and the company provides next of kin with instructions on how to complain about defects. That’s absurd.”—Richard Buetow, Motorola

“If I could have chosen not to tackle the IBM culture head-on, I probably wouldn’t have. My bias coming in was toward strategy, analysis and measurement. In comparison, changing the attitude and behaviors of hundreds of thousands of people is very, very hard. [Yet] I came to see in my time at IBM that culture isn’t just one aspect of the game—it is the game.”—Lou Gerstner, former chairman, IBM

The research that eventually resulted in the publication of *In Search of Excellence* began in 1977. The story is rather long, but the bottom line is that American business was under frontal, and successful, assault, mainly from quality-obsessed Japanese enterprise. The problem, in my and my colleagues’ view, was largely one of misdirected priorities—namely, American managers’ overwhelming emphasis on business strategy and “the numbers first and foremost”—at the expense of people and quality and execution. Eventually, my partner Bob Waterman and I locked onto a group of American companies (subsequently labeled “the excellent companies”) that were mostly “doing it right,” also in the face of stiff competition, and had never lost their focus on what we labeled “the basics.” Our shorthand for the research results was captured in six words: “Hard is soft. Soft is hard.”

Hard is soft: The typical base of “modern management” is mechanical—emphasizing numbers and systems. Yet there is nothing easier than fudging the numbers (look at the likes of Enron and Lehman Brothers); and, alas, most systems quickly become hothouses for exponentially increasing and inevitably debilitating bureaucracy. That is, these “hard” ideas, the bread and butter of MBA programs and consultancies, are anything but “hard,” inviolable truths. Both numbers and systems are, to be sure, unquestionably imperative for running the small business as well as the giant—but they are not the bedrock.

Note: This paper indirectly stems from the current American presidential primaries. Two candidates suggested that the Department of Defense’s wasteful ways could be curbed by ordering the adoption of “6-sigma management.” Having put in two years of Pentagon duty as a naval officer (1969-1970), I was struck by the hilarity of such a notion; I’d observed the “adoption” of miracle systems before in the DOD (PPBS/Program Planning and Budgeting System, the brainchild of Robert McNamara), and watched their inevitable byproducts—*more* bureaucracy and *more* waste,. Moreover, ideas like this, and the issues associated therewith, are near the heart of my last 35 years of professional work. Hence, with some outside urging, and with no political axe to grind on this score, I prepared this brief paper.

“With ISO 9000 [quality standards] you can still have terrible products. You can certify a manufacturer that makes life jackets from concrete, as long as those jackets are made according to the documented procedures and the company provides next of kin with instructions on how to complain about defects. That’s absurd.”

—Richard Buetow, Motorola

Soft is hard: We *did* discover bedrock. It came in the form of deep-seated respect for the work force; managers who were out of their offices and engaged where the work was done (“MBWA,” or Managing By Wandering Around, as Hewlett-Packard called it); an abiding emphasis on trying it (whatever “it”!) rather than talking it to death and then accepting the failures that accompany “a bias for action” as we labeled this phenomenon; keeping constantly and intimately in touch with customers; and “managing” via a small set of inviolable core values. These “soft” ideas, largely AWOL on the American management scene circa 1980, were in fact the “hard” infrastructure of excellence.

Paralleling our work, the quality “movement” took off, and enough “quality gurus” sprouted to fill a sizeable sports stadium. Without a shadow of doubt, the newfound emphasis on quality produced a raft of scintillating success stories—some of which produced extraordinary growth in profitability and market share. Yet a closer look reveals that for every quality program success there were scores of misfires—programs, often absorbing vast amounts of time and sums of money, that produced little or nothing in the way of better quality or improved financial results, and in some situations made a slumping organization even more sluggish.

Though it’s foolhardy to make such an assertion, in my view there was a singular reason for the mixed bag of results; and it was predictable from our excellence research—too much reliance on the apparently “hard” procedures of, say, six-sigma programs and not enough attention to those underlying, apparently “soft” attributes such as the respect for and engagement of the workforce and a personal commitment to excellence.

To support my point, I’ll offer up ten case studies (more accurately, snapshots) of quality programs, often in incredibly resistant environments, that did produce remarkable results. It turns out that they have two principal elements in common:

- * Passionate *local* leadership
- * A bedrock *corporate culture* that supports (or comes to support) an ethos of superior, quality work, courtesy of an engaged and respected and appreciated workforce—and, indeed, an unwavering moment-to-moment commitment to no less than excellence.

(There is an eleventh case study, which focuses on failure—that is, the at least short-term demolition of a culture of quality that had previously consistently produced earth-shattering results.)

Herewith the cases:

Case #1/United States Air Force Tactical Air Command/GEN Bill Creech/“Drive bys”

Case #2/Milliken & Company/CEO Roger Milliken/the 45-minute grilling

Case #3/Johns Hopkins/Dr. Peter Pronovost/The roots of checklist power

Case #4/Commerce Bank/CEO Vernon Hill/The RED button commitment

Case #5/Veterans Administration/Abrogating the “culture of hiding”

Case #6/Mayo Clinic/Dr. William Mayo/Teamwork makes me “100 times better”

Case #7/IBM/CEO Lou Gerstner flummoxed by ingrained beliefs

Peters & Waterman 1977-present:

“Hard” is soft!
“Soft” is hard!

Source: *In Search of Excellence: Lessons from America's Best-run Companies*/October 1982 (NB: Research reported at forbes.com demonstrated that the companies in this book outperformed the stock market, 1982-2002, by a wide margin.)

Case #8/Germany's Mittelstand/excellence-in-the-genes
Case #9/Department of Defense/DASD Bob Stone/tracking down the extant
"Model Installation" superstars
Case #10/Matthew Kelly/Housekeepers' dreams
Case #11/Toyota/Growth or bust

Case #1/United States Air Force Tactical Air Command

You've doubtless seen or heard of "flyovers"—the U.S. Air Force Thunderbirds or the Navy's Blue Angels honoring some significant event with their spectacular aerobatics. But how about the "Drive by"?

General Bill Creech was the 4-star general who commanded the USAF's Tactical Air Command. He was a nut about improving the quality of everything—and wildly successful at doing just that. (He increased battle-readiness dramatically—and in the process also saved a bushel of money.) Sure, there were new systems and procedures. But they were, in fact, the least of it. For example, Creech figured that the key to quality was not the already super-motivated high-visibility USAF pilots, but, rather, the supporting cast of thousands upon thousands who stood behind them such as the brilliantly trained mechanics and technicians and logisticians. Like most supporting casts, these folks were effectively invisible, defining "un-sung" in its literal meaning. Creech moved heaven and earth to change all that. Among other things, at TAC's Langley VA headquarters, he had regular "Drive bys." The mechanics and others would polish their gear and spit shine their shoes and vehicles and, with families and friends and the brass in attendance, hold a celebratory event in which the supporting staff and equipment would parade "full dress" around the base grounds. There were a hundred things like this, quintessential "soft stuff" that added up to a matchless, "all hands" enthusiasm for and commitment to quality work—with no less than staggering results. Moreover, Creech painstakingly developed a cadre of acolytes, generals who subsequently infused this ethos into other commands.

While the new systems that supported the quality program were imperative, it was the new "culture" of all-hands engagement, quality-or-bust as only acceptable outcome, and General Creech's passionate, dogged personal engagement that made the difference.

(NB/Small world: Oddly enough, as I was writing this I ran into, on a hike in New Zealand, a retired USAF pilot. Unbidden, he got to talking about the F-16 rides he'd given to low-ranking airmen who'd performed their supporting work notably well. "*I really took those rides seriously, Tom, as seriously as a combat-training sortie,*" he said. "*We were really trying to honor the amazing work these guys were doing that kept us flying.*" At the time of his comment, he had no idea that I'd ever heard of General Creech or, for that matter, TAC!)

(NB: In this paper, I chose to use interchangeably the likes of "Six-Sigma," TQM/"Total Quality Management," "Deming Principles," Crosby's "Do It Right the First Time," and General Creech's own "Six Pillars." As a result, many readers will doubtless scream bloody murder. But my point is simple: Coherent approaches *are* vitally important! But it really doesn't matter much which one, among the tested ones, you choose—as long as the culture is "right" and the passionate-determined leadership is in place.)

Case #2/Milliken & Company

I met Bill Creech and Roger Milliken at about the same time, in the mid-80s. Roger ran Milliken & Co., the textile giant performing brilliantly against all odds in an industry under crippling assault. In dedicating my 1987 book *Thriving on Chaos* to him, I labeled Milliken & Co.'s commitment to quality the best I'd ever seen. There was indeed a "quality guru" (Phil Crosby as I recall) and new systems had been installed, damn good ones. But make no mistake, the "culture of quality" and war on de-motivating bureaucratic roadblocks that Roger Milliken installed and oversaw with unrelenting (the word was invented to describe Roger) determination made all the difference.

Consider one small, but typical example. When, say, a plant manager from afar arrived at the airport nearest to corporate headquarters, he would invariably be met by "Mr. Milliken," as the boss was called by all except his brothers, and a 45-minute ride would ensue—just the two of them and the driver. The plant manager knew what was coming—a non-stop grilling by Mr. M. on one and only one topic, progress since the last grilling on the quality program and environment thereof. It was a good idea in terms of your future welfare to have something—*45 minutes of significant somethings!*—to say on the way to Spartanburg, SC.

And now consider one *big* example. Milliken was very formal ("Mr. M) and rank-conscious to a fault. Yet when Roger decided to create the role of company president, he passed over all the long-in-line and faithfully serving top candidates and selected Tom Malone for the highly visible new slot. Malone had run a small unit—but had become ardent cheerleader-in-chief for the most successful implementation of the quality strategy and ethos in the multi-billion dollar company. The signal Tom's "deep dip" promotion sent? Very loud and very clear: Get aboard the quality culture train ... or else.

Quality guru? Yes, Milliken had one. Supporting systems? Yes, good ones! But the defining difference was sustained and unwavering leadership from the top and the development of a quality culture in the face of the industry's abiding "culture," which was, in effect, exclusively focused on competing through cost cutting.

Case #3/Johns Hopkins

Patient safety is a hot topic, as it well should be—depending on how you add up the stats, American hospitals alone kill 100K to perhaps even 500K of us per year via largely unforced errors. Near the head of the parade of crusaders for change is Johns Hopkins' Dr. Peter Pronovost, appropriately called the father of the widely touted use of "checklists" in hospitals—and said by one high and mighty source to have saved more lives than any other doctor in America over the last decade! Used appropriately, and they very slowly but somewhat surely are coming to be, checklists *can* result in mind-boggling reductions in errors—e.g., 80% or 90% or even more in places of consequence.

The key phrase, however, is "*used appropriately.*" In his book (with Eric Vohr) *Safe Patients, Smart Hospitals*, Dr. Pronovost takes us through the trials and enormous tribulations of "getting checklists right"—i.e., unleashing the full potential of this "obvious" and "simple" tool, initially at a renowned institution (Hopkins) where the traditional medical hierarchy was deeply entrenched. The key, as is invariably the case in such circumstances, was tackling and then, over time, dramatically altering "institutional culture." For one example among dozens, or hundreds, nurses must be permitted—*required!*—to immediately intervene with docs who skip a checklist step. Talk about 20-megaton "culture change" in an environment where all too many (alas, most) M.D.s treat the likes of nurses with blatant disrespect (alas, "blatant" is the appropriate adjective)!

Taking a somewhat closer look, we find that Peter Pronovost's work was to a large extent triggered by the unnecessary loss of a child, Josie King, at Johns Hopkins Hospital. (The event triggered many things at Hopkins as well as elsewhere and is chronicled in *Josie's Story: A Mother's Inspiring Crusade to Make Medical Care Safe*, by the deceased child's now-crusading mother, Sorrel King.) In his own book, Dr. Pronovost discusses Josie's care, or lack thereof, at a critical moment in the context of a wrongheaded "corporate culture": "*The nurses said they tried to voice their concerns up the chain of command—but no action was taken. The way communication was organized at Hopkins, as it is at*

most hospitals, did not make this easy. Nurses would have to talk to residents, who then passed the message on to chief residents or fellows, who would then talk to the attending surgeons. It is common for the opinion of lower levels of the hierarchy to be discounted and often ignored by higher-ups. ... If someone jumps rank or seeks approval from another surgeon outside of the chain or in any way circumvents this hierarchy, the penalty is often public humiliation and reprimand.

Wow—and, sadly, no surprise whatsoever.

Dr. Pronovost examined the roots of such death-dealing behavior, as reflected in his own training regimen, “When I was in medical school, I spent hundreds of hours looking into a microscope—a skill I never needed to know or ever use. Yet I didn’t have a single class that taught me communication or teamwork skills—something I need every day I walk into the hospital.” Indeed it is precisely the likes of a rare “culture of teamwork,” or the characteristic absence thereof, that makes the apparently straightforward implementation of the “simple” checklist rise or fall—and accounts for the majority of those 100K+ unnecessary hospital deaths due to preventable errors.

The importance of the “system,” that is the checklist per se, is irrefutable! Usefulness of the checklist without culture change, however, was/is marginal or zero or even a step back. (That is, done wrong the checklist becomes another mandated bureaucratic annoyance—which may well worsen rather than improve the already lousy coordination among key actors, such as doctors and nurses.)

Case #4/Commerce Bank

Commerce Bank (now part of TD Bank) created a revolution of sorts in East Coast consumer banking by creating an atmosphere that welcomed customers at a time when most banks seemed to be going out of their way to alienate their retail clientele. In this “case-lette” I’ll focus on one tiny part of one customer-friendly system. Founder Vernon

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Hill (with Bob Andelman), in *Fans! Not customers. How Commerce Bank Created a Super-growth Business in a No-growth Industry*, explains: “Every computer at

Commerce Bank has a special **RED KEY** on it that says, ‘Found something stupid that we are doing that interferes with our ability to service the customer? Tell us about it, and if we agree, we will give you \$50.’”

It’s a “system,” sure, but it’s 95% a transparent “culture-enhancement device”—the focus is on attitude far more than process. That is, the message is, “For God’s sake, we beg each and every one of you to please help improve the quality of the customer experience!”

Case #5/Veterans Administration

Surprising many, Veterans Administration hospitals again and again rank at the top of every list on patient safety/quality of care evaluations. One key reason is the success of the VA staff at developing an understanding of the nature and source of medical errors. That sounds obvious, but as things are, the health care system in general seems perversely designed to keep people (docs, etc.) from admitting and thence analyzing errors. The VA’s Ken Kizer calls it a “*culture of cover-up that pervades healthcare.*” It contrasts sharply with the airline industry. “When a plane crashes,” says James Bagian, M.D. and former astronaut, now working with the VA, “they ask, ‘What happened?’ In medicine they ask: ‘Whose fault was it?’” The latter, of course, is a perfect device for insuring silence.

The VA frontally attacked this pervasive and deadly “culture of cover-up”—and replaced it with a “culture” based on learning from errors. The new idea, as brilliantly reported in Phillip Longman’s *Best Care Anywhere: Why VA Healthcare Is Better Than Yours*, was “looking for solutions, not seeking to fix blame on individuals except in the most egregious cases.” The good (incredible!) news was that as the culture change around admitting errors/learning from errors was established, *and* as the process came to be seen as trustworthy, there was a resulting **thirty-fold increase** in the number of medical mistakes and adverse events that got reported to the “Patient Safety Event Registry.” And the exponentially greater understanding of the source and nature of errors

led in turn to procedural and cultural alterations that make the VA the shining example it has become.

Once more the story is indeed one of a spectacularly useful “system” ... enabled, however, courtesy mind-boggling, “genetic”-level culture change which in turn was enabled by a grassroots-led, passionately pursued (for over a decade) revolution.

Success Key #1: Directly confronting and excising the deeply entrenched “*culture of cover-up*” that pervades medical practice at all levels—and replacing it with a “culture of learning.”

Case #6/Mayo Clinic

Dr. Pronovost may not have had any team training, but there are a few examples of healthcare organizations that “got it right from the start.” One of the two core values instilled by Dr. William Mayo (Mayo Clinic) in 1910 was, effectively, practicing team medicine. (Designing the practice around the patient, or “patient-centered care” as some call its rare manifestation today, was the other core value.)

The potency of Mayo’s team-based culture? Consider this from Dr. Nina Schwenk, a Mayo newcomer: *“I am hundreds of times better here [than in my prior hospital assignment] because of the support system. It’s like you are working in an organism; you are not a single cell when you are out there practicing.”* (Yes, that’s not a misprint: “hundreds of times better.”) Such a culture lends itself to the safer and more effective practice of medicine, for which Mayo may have few if any worldwide peers.

Again: To be sure there are numerous formal systems at Mayo, but the healthful elixir that matters is a peerless culture of co-operation—that dates back to William Mayo’s inspired leadership a century ago.

(NB: The Mayo examples come from Leonard Berry and Kent Seltman’s superb *Management Lessons from Mayo Clinic*. In fact I cannot resist one more jaw-dropping “cultural” commentary from Berry and Seltman. It typically boggles the mind of healthcare professionals in my seminars, who are used to the strict separation of disciplines and hierarchies of authority and power in their own institutions. To wit: “A Mayo surgeon recalled an incident that occurred shortly after he had joined the Mayo surgical staff. He was seeing patients in the Clinic one afternoon when he received a call from one of the most experienced and renowned surgeons on the Mayo Clinic staff. The senior surgeon stated over the phone that that he was in the operating room performing a complex procedure. He explained the findings and asked his junior colleague whether or not what he, the senior was planning seemed appropriate. The junior surgeon was dumbfounded that that he would receive a call like this. Nonetheless, a few minutes of discussion ensued, a decision was made, and the senior surgeon proceeded with the operation. ... A major consequence was that the junior surgeon learned the importance of inter-operative consultation for the patient’s benefit even among surgeons with many years of surgical experience.” Berry and Seltman also report, another jawdropper, that a senior Mayo oversight team more or less routinely disciplines, or even releases, doctors, regardless of technical reputation, who repeatedly fail to practice team medicine.)

(NB: And one more, per my lights, blockbuster: The authors report that in the course of a typical Mayo hiring interview, the candidate is asked to describe a successful project she or he led. The interviewers make careful note of the frequency with which the

“We”

candidate uses

rather than “I” to describe her or his

team’s activities!)

*I am ... **hundreds**
of times ... better here
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assignment] because of the support
system. It's like you are working in
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Case #7/IBM

I first met Lou Gerstner when I was at McKinsey & Co. in the late '70s. The phrase “tough as nails” was invented for the likes of Lou. Only GE’s Jack Welch, among CEOs I’ve met, including generals who ran their nation’s armed forces, is in the same league. Gerstner was also the quintessential McKinsey proponent of “Gimme the facts, period.” He was, in short, an analyst’s analyst—and a superb one at that. My work on organization effectiveness was in its infancy, and though mandated by the Firm’s managing director (de facto CEO), Gerstner thought it was, well, crap. Too “soft” by an order of magnitude!

Time passed, I co-wrote a book about excellence with Bob Waterman (our motto, recall, was “Hard is soft. Soft is hard.”), and Gerstner after a couple of very successful stops-at-the-top, such as American Express, was called in as CEO to save (or dismantle) a staggering IBM. His success was mindboggling, and like so many CEOs in those days, he wrote about it after the fact; i.e., *Who Says Elephants Can’t Dance*. No surprise, I was completely taken by a paragraph that appeared in the introduction:

“If I could have chosen not to tackle the IBM culture head-on, I probably wouldn’t have. My bias coming in was toward strategy, analysis and measurement. In comparison, changing the attitude and behaviors of hundreds of thousands of people is very, very hard. [Yet] I came to see in my time at IBM that culture isn’t just one aspect of the game—it is the game.”

Gerstner extolling the utter inescapable necessity of whole sale culture change? You could indeed have knocked me over with the proverbial feather! Though not directly on the topic of quality, this is in many ways the crowning example in this brief set. Did Gerstner forget about the analytics during his decade-long sojourn at IBM? You gotta be kidding! His love affair with the “hard facts” was never far from the surface. And yet, he faced the hardest of all facts, namely that “soft” really is “hard.” That without tackling the bedrock (hard, eh?) culture issues, a dramatic shift in corporate performance, even survival, was not possible. Lou also came to appreciate that to make such a change he absolutely needed voluntary buy in, not merely a mandate from the top, “In the end,” he said in his book, “management doesn’t change culture. Management invites the workforce itself to change the culture.”

Lou Gerstner?

“Invite”?

Wow!

*“Yet I came to see in my time at IBM that culture isn’t just one aspect of the game—
it IS the game.”* —Lou Gerstner

Case #8/Germany's Mighty "Mittelstand"

Germany's extraordinary economic performance, particularly as high-end manufactured products exporter, is not by and large built on the backs of a few giant institutions such as Siemens or Daimler Benz. Instead the acknowledged bedrock is a stellar set of middle-sized firms—the so-called *Mittelstand*. I studied them closely and even did a PBS television special featuring several Mittelstand firms—it was more or less their first American “public” exposure.

The world of “management thinking,” at the time of my Mittelstand research, in about 1990, was as always awash in buzzphrases—none more commonplace than “empowerment.” Yet as I toured these wildly successful German firms, the spearcarriers for the nation's export excellence, I never once heard “empowerment” (in English or its German equivalent) or “continuous improvement” or their ilk. *Never = Never*. Over time I came to appreciate what I think is the key success factor—and my work over the last 20 years has reinforced that notion. In a word (or words) ... *respect/mutual appreciation*. Superior quality is more or less instinctive in German enterprise; and beneath that “instinctive,” it is a byproduct to a significant degree of the ubiquity of the apprenticeship education and development process. *That process provides a common background and cultural appreciation of superior workmanship among junior and senior workers and their junior and senior bosses—all the way to the CEO*. I observed any number of unstaged exchanges between the CEO-owner (boss of a billion dollar firm) and a 19-year-old line employee that could only be labeled as conversations among colleagues. (Most of us, to put it mildly, think of Germans as rigid and hierarchical—I was taken aback, I'll be the first to admit.) That is, there is widespread respect for and appreciation of craftsmanship and quality work and the initiative required to make it all work—and hence no need for the big boss to call in pricey HR consultants and launch an “empowerment initiative.” Could it be so simple? Of course not! On the other hand, the commonality of my experience throughout visits to a half-dozen companies, ranging from toymakers (Playmobil) to machine-tool manufacturers (Trumpf), I believe strongly supports the argument presented here.

I am hardly saying that systems and measures are not a big part of life in a Mittelstand firm. I am suggesting that they play a supporting role to an incredibly powerful and remarkably widespread national culture of quality work and

self-managed employee on-the-job performance, commitment, accountability, and growth. “Empowerment” consultants need not apply. (I’d also add that virtually all the workforce is unionized—a stereotypical image of union workers focused on “gettin’ the day behind them” is distinctly the wrong image.)

Case #9/Department of Defense Model Installations

Bob Stone was the director of Vice President Al Gore’s mostly invisible and surprisingly effective “re-inventing government” program. His approach at the White House was developed a decade before. When I first met Bob, he was Deputy Assistant Secretary of Defense for Installations, in effect responsible for the status and development of all of our military facilities. He re-defined his DOD task as a headlong effort to achieve nothing short of global excellence. His approach fascinated me—he turned his back on “programs” and “systems,” though he is as much a conservative “systems guy” as anyone I’ve met. In short, he knew from long and frustrating experience that “clever” new systems and programs launched with promises of “transformation” were invariably dead ends in government—that is, their main “products” were increased bureaucracy and constant gaming.

Stone’s extraordinarily effective approach was built around a set of what he labeled “Model Installations.” Given the size of the defense facilities establishment, he figured that there were mavericks out there already doing it right, in fact very right, despite a gazillion bureaucratic impediments; hence, rather than have “brilliant” staff analysts invent “improvement programs,” he cited and publicly honored some small number of stalwart bases as “Model Installations.” He “invited” (shades of Gerstner at IBM) others to learn from the stars’ approaches—which had invariably produced results that put their peers to shame. Stone succinctly captured the notion this way: “Some people look for things that went wrong and try to fix them. I look for things that went right, and try to build off them.” And build off them he did!

(Along the way, Stone *did* attend to the systems per se—and took gargantuan steps to de-bureaucratize them. For example, the principal DOD facilities management guidance document was reduced from 450 pages to eight pages! Stone told me he had wanted to produce the 8-page version in a pocket-size format—however higher-level DOD guidance, beyond his remit, would not permit official documents being printed and distributed in such a revolutionary format. Ah ...)

“Some people look for things that went wrong and try to fix them. I look for things that went right, and try to build off them.” —Bob Stone

Once more, I'm not, to put it mildly, describing an environment short on systems and procedures and measures—but I am describing a context in which local leadership (the model-installation commanders) and a carefully nurtured culture of mutual respect and appreciation of excellence are the dominant drivers of success.

Case #10/Housekeepers' Dreams

The single staff person who has the most face-to-face interaction with the hotel guest is the housekeeper you cross paths with in the corridor and who is responsible for “the little things” in your room that are not in the least bit “little.” We guests all know intellectually we’re sleeping in a room where a thousand others have slept or expressed unattractive habits, but we don’t want to be reminded by the work of a sloppy housekeeper. All that said, the housekeeper is typically the most lightly regarded member of staff—hence, among other things, high turnover and anything but a commitment to service and guest experience excellence. Maybe it’s the residual engineer/MBA in me, but I shy away from books with titles like *The Dream Manager*. But killing idle time in an airport will cause all sorts of odd behavior. Which is to say I aimlessly picked up Matthew Kelly’s *The Dream Manager* in the Atlanta airport—and was instantly hooked. Though written in parable form (I have trouble with that, too), it is the story of a real and outstanding (growth, profits, customer loyalty) cleaning services company—that is, a collection of thousands of de facto housekeepers! (The company chose to remain anonymous—imaging it would be seen by employees as exploitative; I was later thrilled to meet the CEO of the very real firm.)

Kelly, or, rather, the company’s leaders, made an obvious assertion (after the fact—I admit to being bowled over by the obvious time and again) that everyone—yes, including housekeepers!—has dreams. That housekeeper from God knows where is likely a single mom with two kids and three jobs who imagines another more satisfying life if only, say, she could get a community college certificate in business administration or hospitality. Though the CC certificate will not directly make her a better cleaner, it will make her a more fulfilled person—which will indeed doubtless make her a better housekeeper. (It does indeed work!) Given all this, then, the manager’s first job becomes explicitly helping front line folks achieve their dreams—hence, a “dream manager.”

Kelly brilliantly describes the guiding corporate philosophy:

“An organization can only become the-best-version-of-itself to the extent that the people who drive that organization are striving to become better-versions-of-themselves. The question, then, is: What is an employee’s purpose? Most would say, ‘to help the company achieve its purpose’—but they would be wrong. That is certainly part of the employee’s role, but an employee’s primary purpose is to become the-best-version-of-himself or –herself. ... When a company forgets that it exists to serve customers, it quickly goes out of business. Our employees are our first customers, and our most important customers.”

Perhaps you’d say, as I did at first (yes, even me, Mr. “Soft is hard”), that “dream manager” is a bit over the top. Yet it works—and has produced bottom line excellence and service excellence for years. And once more, as I talked with Kelly and then the company founder, I discovered that, of course, there are procedure manuals and time-tested systems—damn good ones, in fact. But it’s not those manuals that have produced the exceptional results—it’s a clutch of “mere” housekeepers pursuing their dreams and becoming more effective and fulfilled human beings.

*“We all have
dreams.”* —Matthew Kelly

*“We are ladies and
gentlemen serving
ladies and
gentlemen.”*

—from the Ritz Carlton Credo

NB: The Ritz Carlton hotels, under the inspired leadership of Horst Schulze, set a standard for hotel service quality. The organization's "credo": ***"We are ladies and gentlemen serving ladies and gentlemen."*** Sound mundane? Well, it's not. Perhaps the large majority of the front-line staff who almost singlehandedly shape the customer experience—housekeepers redux—have been treated like anything but "ladies and gentlemen." A single word ("lady" or "gentleman") does not excellence make—but it sure as hell helps! As to the idea (I'd say *profound* idea) of employees as "customers," the remarkable Herb Kelleher, Southwest Airlines founder and longtime CEO, always insisted that there was a single primary underpinning for his company's excellence in a brutally competitive environment: *"You have to treat your employees like customers."* Related favorites of mine: From health and beauty-salon chain founder John DiJulius: *"When I hire someone, that's when I go to work for them."* And Arie Weinsweig, founder of the world renowned food emporium Zingerman's: *"If you want staff to give great service, give great service to staff."* (NB: At the Ritz-Carlton, those housekeepers are permitted to spend \$1,000+ to fix a guest problem—without the approval of "management." A lot of middle-managers are not allowed that much leeway!)

Case #11/Toyota

Toyota's systems have long been the envy of the world—ensuring quality matched by none. Or so was the case for several decades. In the last few years, alas, Toyota has become a poster child for quality problems, some of which are purported to have resulted in fatalities. While it's admittedly absurd to pin a problem of this magnitude on a single variable, it seems almost certainly to be more or less the case in this instance.

Closing in on a then-stumbling GM, Toyota pulled out all the stops in a rush to become the world's largest car company in terms of sales. While the objective was achieved, it seems to have come at the expense of a proud culture of quality and excellence, which was effectively replaced by a culture of more along the lines of "growth-at-all-costs."

As a result of the ensuing quality mis-steps, which clearly dented customers' faith in the product, top leadership was revamped, apologies were made by the Toyoda family, and new family leadership was installed at the top—the results, happily, are promising.

When we speak of Japan's enterprise success, particularly in the quality and continuous improvement arena, we talk often of systems—"CI"/continuous improvement or "lean production" or the "Deming Principles." Dr. Deming's approach did work miracles in Japan, but the lessons extracted therefrom were misleading. Deming may have had a scheme, but it was based almost entirely on an enabling "corporate culture" of employee commitment to quality; moreover, in Japan, the existing national culture and approach to work were tailor-made for implementing Deming's prescriptions. Of course, as suggested in this brief example from Toyota, even the most effective of corporate cultures can be torpedoed, at least in the short term.

The most effective cultures imaginable—e.g., Toyota's—can slip, slip badly, and slip astonishingly quickly. Sustaining a culture of quality and excellence is a daily affair. And a conscious daily affair! Leaders at all levels must explicitly assess their daily performance to gauge the degree to which they have stayed true (or not) to the cultural imperatives of an organization devoted to matchless quality and an invariant standard of excellence.

Systems Have Their Place: **SECOND** Place

These eleven case studies capture the lion's share of the organizational universe. E.g.: the public as well as the private sector. Our fastest growing "industry," healthcare, as well as the poster child for embattled industries, textiles. Non-USA entities—Toyota and the German Mittelstand—as well as American institutions. The life of USAF pilots—and the life of hotel housekeepers. The stories are, obviously, intentionally repetitive. They effectively make the same point again and again: Systems and procedures are necessary but nowhere nearly sufficient. In fact, in the absence of fired up local leadership and a supportive organizational culture that starts with respect for the contribution of every employee, elaborate systems can readily become additional bureaucratic drag.

To an extent, this discussion is pessimistic. There are no miracle cures. There are no clever systems that will in and of themselves carry the day. If you don't have an effective culture taking the lead, you are pretty much doomed to marginal improvement, or, God help you, steps back by merely installing a system, no matter how ingenious or how highly touted it may be.

*In the end: **Hard is soft.***

***Soft is hard.** The traditionally viewed "soft" variables such as "institutional culture" and "inspired leadership" are the principal keys to success—or failure.*

Golden Bay, New Zealand/14 February 2013
(West Tinmouth, Vermont/0107.14)

Closing notes:

(1) While I have consistently indicated to the contrary, one might assume that I am giving systems short shrift. To be sure, I am emphasizing the incompleteness—and often problematic nature—of a strategy that envisions superior systems as a be all and end all. But, trained as I am, first and foremost, as an engineer, I am hardly indisposed to superior systems—organizations do indeed need to be organized, and systems are the scaffolding for effectively organized affairs. In fact, an approach to doing business that brushed off systems and effectively stopped with a culture that was, say, highly supportive of staff would also by and large be dysfunctional. In short, one needs both superb systems *and* a culture that unmistakably “puts people first” in pursuit of quality and overall excellence. The purpose of and impetus for this paper is, then, primarily is to act as a corrective to the traditional approach that, so often, emphasizes systems and de-emphasizes—or ignores!—the sort of organizational cultures described briefly in the cases above.

(2) A related point, a source of continued irritation to me: I am *not* talking about “balance”—a word I dislike! That is, the cases above are do not “balance” culture and systems—they are, de facto, cases of, if you will, “double excellence.” The systems at, say, TAC are superb—*and* the TAC culture instilled by General Creech is appropriate to maximizing the value of those systems and, hence, producing overall excellence and superior results.

**Culture first, systems imperative-but-second ...
but for sustaining excellence in quality and
productivity and performance excellence,
you’ve gotta do both with panache!**