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 behavior 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 <u>is</u> 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' 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 "doing it right," and had never lost their focus on 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" had become 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.

***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 absent 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 dangerous 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.

To support my point, I'll offer up nine case studies 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 and, indeed, excellence as standard fare.

(There is a tenth 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 by"
Case #2/Milliken & Company/CEO Roger Milliken/the 45-minute ride
Case #3/Johns Hopkins/Dr. Peter Pronovost/checklists
Case #4/Commerce Bank/CEO Vernon Hill/RED button
Case #5/Veterans Administration/"culture of hiding"
Case #6/Mayo Clinic/Dr. William Mayo/"100 times better"
Case #7/Toyota/growth or bust

Case #8/IBM/CEO Lou Gerstner flummoxed
Case #9/Germany's Mittelstand/in the genes
Case #10/Department of Defense/ASD Bob Stone/"Model Installations"

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 honor some significant event with their spectacular aerobatics. But how about the "Drive bys"?

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 high-visibility USAF pilots, but, rather, the supporting cast of thousands that 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" things, that added up to a matchless, "all hands" enthusiasm for and commitment to quality work—with no less than staggering results. Moreover, Creech 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 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" interchangeably. As a result, many readers will doubtless scream bloody murder. But my point is simple: Systems *are* terribly 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 dedicating my 1987 book *Thriving on Chaos* to him, I called Milliken & Co.'s commitment to quality the best I'd ever seen. There was indeed a "quality guru" (Phil Crosby, as I recall), and systems had been installed, damn good ones. But, make no mistake, the "culture of quality" that Roger Milliken installed and oversaw with unrelenting determination made all the difference.

Consider one small, but typical example. When, say, a plant manager 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. 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 hierarchical to a fault. Yet when Roger decided to create the role of company president, he passed over all the long- and faithfully serving top candidates and selected Tom Malone. Malone had run a small unit—but had become ardent cheerleader-in-chief for the most successful implementation of the quality strategy 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 "culture," which was, in effect, exclusively focused on cost cutting.

Peters & Waterman 1977-2012:

“Hard” is soft!
“Soft” is hard!

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 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. 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" tool, initially at a renowned institution 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 checklist steps. Talk about 20 megaton "culture change" in an environment where all too many docs treat the likes of nurses with blatant disrespect!

At one point in the book, Dr. Pronovost reflects, "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.

The importance of the "system," that is the checklist per se, is irrefutable! Usefulness of the checklist without culture change, however, 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 co-ordination among key actors such as doctors and nurses.)

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"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." **—Dr. Peter Pronovost**

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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 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 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 systematic 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 a *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 lead in turn to procedural 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, only by mind-boggling, "genetic"-level culture change which in turn was enabled by a grassroots-led, passionately pursued (for over a decade) revolution.

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Success Key #1: Directly confronting the deeply entrenched *"culture of cover-up"* that pervades medical practice at all levels.

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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 William Mayo (Mayo Clinic) in 1910 was, effectively, practicing team medicine. (Designing the practice around the patient, or "patient-centric care" as some call its rare manifestation today, was the other core value.)

The potency of a team-based culture? Consider this from Dr. Nina Schwenk, a Mayo newcomer: *"I am hundreds of times better [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 no worldwide peers.

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 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."*)

(NB: And one more, per my lights, blockbuster: The authors report that in the course of many interviews, the candidate is asked to describe a successful project she or he led. The interviewers make careful note of the frequency with which the candidate uses **"We"** rather than "I" to describe her or his team's activities!)

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***"I am … hundreds of times … better [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."*—Dr. Nina Schwenk**

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Case #7/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 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 stumbling GM, Toyota pulled out all the stops in a rush to become the world's largest car company. While the objective was achieved, it seems to have come at the expense of a proud culture of quality and excellence being replaced by a culture of more along the lines of "growth at all costs."

As a result of the 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.

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"; 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—though one suspects that the deep roots of the longtime effective culture will result in a rather rapid comeback.

Case #8/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, Gerstner though 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 behavior 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 the 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 #9/Germany's 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 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 buzz phrases—none more than "empowerment." Yet as I toured the German firms, I never 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 a number of un-staged 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. 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 to machine-tool manufacturers, I believe strongly supports the argument above.

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, accountability, and growth.

Case #10/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.)

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 excellence are the dominant drivers of success.

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***"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**

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Systems Have Their Place: SECOND Place

These ten 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 stories are, obviously, intentionally repetitive. They make the same point again and again: Systems and procedures are necessary but no where nearly sufficient. In fact, in the absence of fired up local leadership and a supportive organizational culture, 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 irrelevance or steps back by merely installing a system, no matter how ingenious or how highly touted it may be. You've either got to have a supportive culture or take on an unsupportive one, though as the final example from the Department of Defense suggests, you can use an indirect approach—find and build off those extant rebels already doing it right in their nook or cranny.

In the end: Hard <u>is</u> soft. Soft <u>is</u> 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/31 March 2012