Ongoing Discussion "Thought Piece"

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Deming's Message for Me
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Introduction: When I was the Commanding Officer of the Naval Aviation Depot at North Island Naval Air Station in San Diego, my good friend Bill Cooper came to me one day and asked, "Have you ever heard of Dr. Deming?" I said I'd heard the name, but didn't know much about him. "Would you like to meet him?" Bill asked. "Sure, I always like to meet famous people." Little did I know that my life was about to change.

The forum was a group of leaders who met with Dr. Deming for an evening when he was on the West Coast conducting one of his four-day seminars. This night, we sat in front of about 300 of our supervisors and asked Dr. Deming questions. I did not know, but soon found out that Dr. Deming was kind, even gentle to people he called the, "Hourly Worker". But he was caustic as hell to top management and I was the Commanding Officer. In an answer to one of my questions he yelled at me saying, "Captain, if that is the way you are acting, you are breaking the law!" That was my conversion moment. Few people have such a dramatic moment in their lives recorded, but I have mine. I walked away from that evening thinking two things;

1. Dr. Deming was right in what he said.
2. I had a lot of learning to do.

I had achieved many things in my career and important positions. I was a firm believer in Management by Objectives, setting goals, and holding people responsible and accountable. It all went out the window that fateful evening and a new life began for me.

Those who have read and studied Dr. Deming know of his fourteen points, his Theory of Profound Knowledge, his focus on Customer Service, and the fact that Japan's top prize for an organization is named, "The Deming Prize". You may not know that in 1995, the new speaker of the House of Representatives, Newt Gingrich, gave a 20-hour lecture series at Reinhardt College in Georgia titled, "Renewing American Civilization". He talked about the five pillars of America that make us great which included:

1. Our Historic Lessons
2. Personal Strength
3. Entrepreneurship and Free Enterprise and
4. The Spirit of Invention and Discovery.

The fifth pillar of American Society that makes us great according to Gingrich is, "Quality, as Defined by W. Edwards Deming." To me, that is a huge

endorsement of Deming's Theory. Find more about this seminar online at http://terrenceberres.com/ginren00.html

When I am asked to speak about Dr. Deming, it is hard to sift through all that he taught and present a meaningful program. After all, Dr. Deming took four days for his famous seminar and many visits to organizations that he consulted with. "There is no instant pudding," he would tell audiences. Still, I think it is important to find a kernel or two that were the most important messages to me. I have done that in this paper, plus a thought of why Dr. Deming's message did not, "Catch On" as a uniform Theory of Management across our country.

Kernel Number 1: 90% - 95% of what happens in an organization is a result of the processes they use, not the people.

There is an interesting history of the numbers used here. The first Deming Seminar I attended he used, "85% is a result of the processes". Later on he said, "90%" and in time, "92% - 95% was a result of the processes used". Finally, in 1993 at his last seminar in Los Angeles, ten days before his death he is quoted in the Los Angeles Times by a reporter who interviewed Him as saying, "Everything that happens is a result of the process! People don't know that! It's incredible!"

This led to a huge change in my leadership for I became a, "Process Manager", as opposed to a, "Project Manager". I think it was Myron Tribus whom I first heard say, "People work in the system, Managers work on the system." That became my mantra and my task; to focus on the system. I learned the system is primarily made up of different processes that are created to achieve a pre-determined outcome. It was up to me to manage the processes. . I feel there is compatibility here with Russ Ackoff who said, "There is a rule for the real world; 90% of the problems that confront us cannot be solved where they first appear. They have to be solved somewhere else that requires cross disciplinary work." I usually add, "They have to be solved in the Board Room."

So when something bad happened, I started to ask, "What in the Process permitted that to happen?" I did not ask, "Who did it?" That was a profound change for me.

I submit that most leaders today are, "Incident Managers". Something happens, it might not be as planned, and they want to know, "What went wrong", "Who did it", and then leave saying, "Make sure it never happens again". Often, the person

involved will be fired or punished in some way. Not a good thing for a rising career.

Case Study One: In early 1986 I was in charge of Navy aircraft readiness for the U.S. Atlantic fleet. We had an aircraft carrier deployed in the Mediterranean that was having difficultly keeping a piece of electronic equipment working, and therefore had a degraded state of readiness. The three star Admiral I was working for asked me, "Do we have to fire the supply officer and the maintenance officer and get some people over there who can do the job?" I told him I would look into the situation and return with a recommendation.

What I found out was that the equipment in question was a Model ____A. There was a new Model ____B developed and back in 1982 the Supply System leaders made the decision that after 1985 we would never again deploy the Model ___A (this was now 1986). There had been production problems with the new model, the Government inspectors would not accept the units, and we were forced to deploy the older models. In truth, we had no idea about the 1982 decision not to purchase support after 1985.

I returned to the Admiral and said, "They don't have a problem in the Mediterranean, we have a problem here." His response, "If we have a problem, then Phil, you have a problem." He was correct. It took many actions to get the deployed forces the support they required but we did it. The story has a good ending; both officers involved were promoted to the next higher rank when due. I firmly believe that if I had not been exposed to Dr. Deming's theory of management, we would have replaced the two officers and two careers would have been ruined.

Case Study Two: I served on the Board of the Metropolitan Transit System (MTS) when I was on the Coronado City Council. One day I became aware that one of our buses carrying school children home missed a stop on Highway 75, and let the students off about 100 yards from the protected bus stop. The students then had to walk across a four-lane highway, traverse a three-foot center median barrier, with cars traveling by at 65 MPH or greater. This was an unsafe situation. I called the MTS Executive Director and reported the incident.

It wasn't long before I received a call to inform me the driver had been identified, counseled, and given three days off work without pay as punishment. I was told, "It won't happen again."

I asked, “How long had the driver been employed?” “How many times had the driver been on this route?” I knew that this particular bus stop is unusual. It is in the center of the highway and a bus has to be in the fast lane to correctly enter the island and discharge passengers.

What I found out was, this driver had been working for MTS for six weeks; had completed training two weeks before the incident, and this was the first time that the driver had been on this particular route. She was not aware of the special configuration or location of the bus stop and therefore, missed it. No one was injured but I ask the reader, was it the bus driver’s fault, or the Training Officer’s fault? I have to admit I was unsuccessful and made enemies when I insisted that the Training Officer and the Executive Director receive the same punishment as the driver. In my view, it was their system that did not adequately prepare a new driver for the challenge faced.

I could go on for days relating situations where something bad happened and a person was blamed when the process was the culprit.

Kernel Number 2: Managers must know the difference between a special case (or, special cause) and common cause variation.

It is difficult for American managers to admit that a process could be the cause of the problems that they face. On the other hand, sometimes a special case does arise, it most likely will never happen again, and leadership makes process changes to insure that the same mistake will not be made. This can be very expensive, and a waste of resources. I will provide an example of each.

Case Study Three: When I was Commanding Officer of the Rework Facility, one of our concerns was Equal Employment Opportunity (EEO) complaints. When we received a complaint, we would investigate it. Upon completion, we would take the recommended actions which usually included counseling those involved. We would hope it would never happen again. We treated each EEO complaint as a special case.

One day after hearing Dr. Deming, I asked how many EEO complaints had been filed each month, for the last 24 months. I plotted the data on a control chart and found the average was 10 complaints each month, the upper control limit (UCL) was 18 and lower control limit (LCL) was two. Given we had 6,000 employees, some might think this wasn’t an unusual number. I thought it could be improved.

I shared with our leadership team my conclusion. "We have a System at North Island that creates EEO complaints." We decided we had to attack the culture and the system if we were going to see improvement in this area. We took specific actions such as increased supervisor training, personal briefs by the Commanding officer, and special instructions on how to conduct selection panels for a more open process. While complaints did not disappear, the average dropped to five a month with an UCL of 8, LCL of 2. Attacking the System resulted in improvement. The prior method of treating each complaint as a special case provided no improvement over many years.

Case Study Four: In Coronado, when an issue comes before Council that involves a significant change to a property in the City, notice is required to be mailed out to all people residing within 300 feet of the property involved. In one case, about 30 of the closest neighbors failed to received the notice, and were terribly upset. They took the issue to court.

When the City Manager investigated what had happened, it was determined that the individual responsible for sending out the notifications was working on the projects, didn't feel well, and left work for what was later determined to be a mild heart attack. A second person saw the envelopes ready for mailing, sent them out, and thought the project was complete.

The City Manager explained this to our Council and finished by saying, "It will never happen again. I have instituted a process where the list of people within 300 feet is checked by a second person, and the envelopes are then checked by the second person against that list before they are mailed.

In private, I told our City Manager I appreciated the brief but felt he had not provided a Quality Solution to the problem. He asked my, "Why?" and I responded, "You made a process change for a special case. That change will cost time and money over the years because an employee had a heart attack. I feel that is wasteful and unnecessary." If I were honest I would guess that the double check is still in place with money time being wasted. Incident managers do that!

Bonus Case Study Five: Bill Cooper and I were consulting with an Engineering Company who supported the Department of Energy. The company bid different projects, formed project teams, and set about to accomplish the work. We analyzed twenty projects that were recently completed or near completion. Guess what? All were on schedule and at or below cost. There was

astonishment on the faces of the top supervisors when we said to them, “Your folks are cooking the books!”

With just a basic knowledge of the Theory of Variation, an enlightened supervisor would understand that if the projects were bid correctly with respect to cost and schedule, half should be ahead and half should be behind. As it was, bids were being, “Padded” to make sure the commitments would be met. There was no honesty because jobs were at stake if a project was behind schedule or over cost. Dr. Deming said, “Drive out Fear!” This system had built in fear and hence, inflated information.

Conclusion: Some wonder why Dr. Deming’s Theory of Management never became widespread in America. I think a main reason is that Dr. Deming pointed straight at top management, and said, “You are in charge!” That meant that if something goes wrong, the top of the organization is accountable. Most Senior Managers want to set up a system where they are not accountable, and they want to blame the people in the organization when things don’t go exactly as planned. They will not ask the question, “What in the process caused that to happen?” To me, that is the key question for quality improvement in any organization.

My favorite story about this occurred at the end of a four day seminar in San Diego. Dr. Deming would usually end with about an hour of questions. This day, a senior executive had pretty much had it and with emotion asked Dr. Deming, “Isn’t it possible that there could be a bad worker, one that should be fired?” Without taking a second Dr. Deming asked, “Why did you hire them?” “Wasn’t it your process that determined they were a good fit for your company?”

And once again he put Senior Management in Charge. That is where Quality starts. I don’t think there is a better way.

Biography

Phil Monroe served eight years on the Coronado City Council. Prior to that Mr. Monroe served five years on the Coronado Planning Commission, the last two years as Chairman. He represented Coronado on the SANDAG Board and the San Diego Metropolitan Transit System Board for six years. For thirty years he was an Officer in the U.S. Navy where he held positions in engineering, logistics, and direct fleet support areas. When Phil was Commanding Officer at the Naval Air Rework Facility, North Island, he introduced the Deming management theory to that organization which employed 5,500 personnel and managed an annual budget of over $400 million dollars.

After leaving the Navy, Phil consulted with major companies, helping them develop their Quality Improvement and Performance Measurement implementation strategy. Phil has a unique talent that helps organizations connect their strategic plans to a meaningful measurement strategy. His friendly style and “How to” approach clarify key points to promote learning.

Phil was a founding member of the In2:InThinking Network’s Board of Directors. He current serves on the board of the Coronado Historical Association, the Coronado Tennis Association and is Chairman of the Board of Full Access Coordinated Transportation (FACT) that works to meet the transportation needs of Seniors, the disabled and people in Social programs.

Mr. Monroe’s degrees include a BA (Mathematics) from Cornell University and an Engineers Degree in Aeronautical Engineering (AeE) from the Naval Postgraduate School. Hobbies include tennis, golf, and rollerbladding. With his wife, Fran, they maintain a love and concern for four daughters.