The Controversy over Diagnosis in Contemporary Organization Development

By Robert J. Marshak

Diagnosis, it seems, has become somewhat of a dirty word among many of today's organization development (OD) practitioners. Even people who were leading contributors to the OD diagnostic literature now question its usefulness or even legitimacy in most situations (e.g., Weisbord, 1976, 2012). Given the importance placed by the founding theorists and practitioners on an action research process typically described as including entry, contracting, data gathering, diagnosis, feedback, intervention, evaluation, and exit (Anderson, 2012, p. 98) this is seen by some as a disturbing development and by others as a welcomed advancement in theory and practice.

Concerns about Diagnosis

The reasons given by many of today's practitioners for moving away from diagnosis in OD are plentiful and persuasive. All seem directly related to dictionary definitions of *diagnosis* and/or its implicit everyday usage:

» The art or act of identifying a disease from its signs and symptoms
» Investigation or analysis of the cause or nature of a condition, situation, or problem

All have also emerged mostly from the mid-to-late 1980s with the development of dialogic and other change technologies not predicated on the classic data collection – feedback model of early forms of OD, such as Appreciative Inquiry, Future Search, World Café, Open Space, and more recent interventions based on the complexity sciences and concepts of emergence and continuous change. The reasons for moving away from diagnosis given by proponents of these and other related approaches usually include some or all of the following:

1. Diagnosis explicitly or implicitly invokes the doctor-patient model. Whether in Beckhard's early definition that "Organization development is an effort...to increase organization effectiveness and health..." (1969, p. 9), or just part of our socialization, diagnosis is said to inherently imply an expert treating a patient, with the resulting conscious or unconscious biases towards that type of relationship and actions. "Although Lewin's model does not assume sickness, it is easy to infer for those of us socialized to the medical model with diagnosis its most sacred act" (Weisbord, 2012, p. 261).
2. Diagnosis, whether implicitly invoking the doctor-patient model or not, still assumes there is a problem to be addressed that requires an objective expert to help with an analysis of the real causes. Afterall, one of the reasons given in early formulations of OD for conducting a diagnosis is to test whether the "presenting problem" of the client is, in fact, the "real problem" needing to be addressed (Block, 1981, p. 144). Whether operating from a biological model of health where the causes of sickness need to be discovered and treated or from a more mechanical model where the machine-like organization is broken or has a problem that

needs to be fixed, the presumption is to find and remedy the debilitating condition and its causes. Aside from raising questions about who knows best in the consultant-client relationship or if the consultant can ever be an objective observer, this orientation is one that is problem-centric and focused on deficiencies rather than being possibility oriented and/or strengths-based. This has been one of the principal ways proponents of Appreciative Inquiry since its origins in the 1980s have sought to differentiate their approach from foundational OD.

3. Whether intended or not, diagnosis can become the special domain of the consultant who may select the diagnostic model(s) and methods for data collection and feedback. This again has a tendency to thrust the OD consultant into an expert authority role rather than a collaborative change partner one. And, of course, early lists of competencies required by OD consultants included diagnostic abilities as a fact-finder or researcher (e.g., Lippitt and Lippitt, 1978). Furthermore, diagnosis assumes there is an objective reality that the unbiased consultant helps to discover rather than understanding that the consultant is also a participant in the emergence and construction of an organization's social reality.
4. Diagnosis at best can only capture a moment in time and in today's world of rapid and constant change it inherently provides an out of date picture for the client system to work with. By the time contracting is completed, a diagnostic process initiated, data collected, responses prepared for presentation, and a feedback session conducted conditions could have shifted in important ways. This has always been a limitation of the data-feedback model, but it has become an increasing concern with the shift to today's world of hyper-active systems and continuous change (Marshak, 2004).
5. Our emerging understanding of organizations and organizational processes is too complex for any diagnostic model to accurately capture. Leading models of organization diagnosis such as the Burke-Litwin Causal Model, Galbraith Star Model, McKinsey 7-S Model, Nadler-Tushman Congruence Model, and Weisbord 6 Box Model, may capture many important factors, but they also all leave out potentially important dynamics (e.g., organizational politics) or are unable to account for the relationships posited by, for example, complex systems theory that go far beyond simple cause-effect models of organizational dynamics.

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Are the Concerns Overstated?

All these critiques, while certainly having some validity, may also be overstated by those advocating OD approaches that differ in varying degrees from the foundational data collection-diagnosis-intervention sequence wherein the OD consultant does not advocate an intervention approach until after a diagnosis is completed. In that regard they sometimes can begin to sound like "talking points" used by those who seek to accentuate how and why what they are doing not only differs from, but is better than, traditional OD action research approaches.

One set of rejoinders, therefore, in this current debate include some or all of the following:

1. Diagnosis assumes the Doctor-Patient Model. This, of course, is explicitly not what the OD consulting relationship is intended to be and is a source of constant vigilance in OD theory and practice. Schein, for example, is especially clear about this in the early pages of his classic work on process consultation where he criticizes the doctor-patient model of consulting and calls instead for a collaborative client-consultant relationship on all matters (1969). Speaking from my own experience as one of the early generation of practitioners taught OD principles by the founders, avoiding the expert "tell clients what to do" model in favor of a collaborative relationship was virtually the prime directive for becoming an OD consultant. In practice this might occasionally prove difficult when client wishes for expert answers as well as consultant egos invite stepping into the doctor/expert role, but explicit OD theory, practice, and ethics provide constant warnings to avoid that path.
2. Diagnosis is Problem-centric. Along with concerns about implicit biases towards the doctor-patient relationship the worry that diagnosis is inherently and only problem focused may be overstated. Yes, certainly the purpose of diagnosis in OD could include discovering the potential factors contributing to a current problematic state. However, diagnosis could also help identify potential factors needing to be leveraged or strengthened to achieve a desired future state. In terms of the diagnostic aspects of force-field analysis there can and should be attention to both limiting and positive factors in

any change situation. OD also includes practices wherein participants identify a desired future and then consider (diagnose) what needs to happen to achieve that positive vision.

3. Diagnosis is the Special Domain of the Consultant. Certainly there are times and practices within a formal diagnostic step when the OD consultant might exercise greater authority, expertise, and somewhat independent action regarding the client and client system. This includes choices or strong suggestions about what diagnostic model(s) or dimensions will be considered, what data will be collected, what will be the means and methods of data collection, what data will be fed-back and in what format, and the intended processes and participants involved in working with the data (e.g., Nadler, 1977). This does not mean, however, that clients are or should be excluded from the planning or execution of a diagnostic step. OD theory and practice invite collaborative joint actions throughout the consulting relationship and this includes diagnosis. Clients should be involved in co-determining and carrying-out what data should be collected, by whom, using what methods, from which people, at what locations, and how that data will be configured and presented to which stakeholders using what processes. In that sense the OD consultant is clearly a partner in diagnostic meaning making and not a purely neutral, outside observer. In short, in practice the range of client involvement in diagnosis can range from active involvement to closely informed bystander, although in my experience OD theory suggests it should tend more towards involving the client system in the diagnostic process as much as possible. This could include designing questions, carrying-out interviews, aggregating and presenting the data, and designing and conducting meetings to determine what the data may mean and what actions to initiate.
4. Diagnosis Takes Too Long for Today's Fast Paced World. The pace and rhythm of many of today's 24/7, globally connected workplaces experiencing continuous change may be different in degree and kind from the industrial age workplaces of the 1950s-70s. Taking an extended period of time to collect data and diagnose an organization before considering action may not be a viable option in those settings. At the same time diagnosis does not have to take months and months to perform. Important data can be collected and important insights garnered to help guide a change approach in a matter of weeks or even days. Even in the most fast paced organization experiencing continuous change a few weeks of data collection and diagnosis of what might be going on to help lead into action taking meetings and events is not so slow as to make the data invalid and out of date. In fact, more abbreviated forms of diagnosis have been part of OD consulting practice for at least as long as the almost 40 years I have been a practitioner. For example, I and others under a range of circumstances might ask during entry and contracting to be able to talk to a few - or quite a few - people before proceeding further. This was a deliberate diagnostic step to insure a meaningful contract and approach as well as to minimize potential surprises.
5. Organizations and Organizational Processes are too Complex for any Diagnostic Model or Approach. The nature of today's organizational world combined with an increasing array of organizational and change theories advanced since the foundation days of OD have added to the complexity of trying to understand organizational phenomena. Consider that such concepts as social construction, organizational culture, organizations as meaning making systems, continuous change, and complex adaptive systems have both enriched our understandings and also increased the array of possible explanatory variables, factors, and relationships. Add to that multicultural global organizations operating in rapidly changing and highly competitive industries and it becomes clear that no one theory or diagnostic model can encompass all the factors and relationships that may be influencing the way things are and could become. The fact that no one theory or model encompasses everything, however, does not necessarily mean that no theory or model is useful, nor the possibility of selective use of different diagnostic models depending on informed judgment about what might be most appropriate in a particular situation. After all, in physics there are multiple competing theories for different phenomena including notions that light is both a particle and a wave. It is widely recognized that each theory captures only part of the complex physical world and also that each provides useful and instrumental value in engaging aspects of that world. The fact that the organizational world is highly complex does not mean that the selective use of some type of formal diagnostic process to seek an informed approximation of what might be involved in a situation is not potentially worthwhile. Furthermore, formal diagnosis does not have to involve using one model or focus alone. Diagnostic approximations addressing organizational dynamics, group dynamics, leadership behavior, and issues of power, authority and conflict, among others, might all be useful in an OD engagement whether as part of a formal diagnostic step or implicitly during the life of a consulting engagement.

What has been covered so far might be considered a condensed version of some of the point and counterpoint discussions that in my experience are occurring in the OD community via articles and books, presentations, and hallway discussions at various conferences and meetings, and in OD-related workshops and degree programs. As such they illuminate many of the issues and considerations regarding diagnosis in contemporary OD, but present practitioners, especially newer practitioners, with conflicting arguments about how OD should be conducted. What if, however, both were roughly true? What if instead of either/or we tried to think in terms of both/and? What might that discussion sound like?

Even if the Concerns are Mostly Valid is there Still a Role for Diagnosis in Contemporary OD Practice?

I do not profess to have a well rehearsed version of both/and to convey to you at this time and place. Instead, I would like to illuminate that way of thinking by discussing the possibility that both sets of positions may have applicability. Put another way, what if the concerns about diagnosis in contemporary OD were all true or mostly true? Would that invalidate the use of diagnosis in all situations? Let us review the arguments again and see. For the sake of this presentation the five main concerns listed above are grouped into two categories: 1) concerns about an expert, problem-oriented, and consultant driven diagnostic process, and 2) concerns that the speed and complexity of today's organizational world make diagnosis at best an outdated, limited focus, snapshot in time.

First are the concerns about an implicit tendency to move into an expert relationship that is deficit-oriented and problem-centric, and wherein the consultant has the preponderance of influence in the diagnostic process. For the sake of this discussion, what if this was roughly true? Are there still any set of conditions when one might still include formal diagnosis in an OD engagement? In the extreme, the answer in OD theory and practice would be "no," but what if we adopted a more nuanced stance that was not totally black and white?

What if the client and client system were somewhat ambivalent or even reluctant about proceeding with a change initiative and needed the psychological assurance that they were working with a very knowledgeable and experienced practitioner? In addition, what if they were very clear about a specific problem or developmental objective they wished to accomplish and might not need complex or transformational change? What if furthermore a valid (to them) process of data collection and diagnosis would help reassure or convince them of the need to change and enhance their confidence in working with an OD consultant on possible intervention strategies? While it is true that OD consultants seek to avoid the expert authority role it is also true that whether they like it or not, they occupy a type of authority role and also have expertise in collaborative helping and processes of change. It is also true that sometimes an OD engagement might be requested in order to address a relatively straightforward problem or deficiency. Not all change projects necessarily involve complex, whole system, transformational dynamics. Finally, for more bounded problematic situations where some type of data and feedback might help convince a leader, team, or set of stakeholders to endorse and pursue a course of action, having that information provided to them through processes involving an unbiased, experienced outsider might be essential. Do these conditions in some form or another apply to all potential OD projects? No. Might they apply to some or a class of potential OD projects? I would have to say yes.

The second set of concerns involves the speed and complexity of today's organizational world. Here the concern is that diagnosis cannot capture the ongoing or emerging dynamics of rapidly changing complex organizational systems. Again, at the extreme the answer is probably that diagnosis is of little or no value under such conditions. However, not all organizations fully meet such conditions. Yes, things move quickly in today's world, but not at overnight speed on all dimensions. The premises of complexity science might be fully applicable in specialized instances of the physical world, but might also be considered more like analogies or approximations in the social world of organizations. It is also true that diagnoses can be helpful without necessarily having to account for every possible variable or relationship. Certainly all of us navigate the complexities of our everyday lives without a full understanding of all the variables and their relationships. What we do have and what is needed in organizational diagnoses are good enough instrumental approximations of what to pay attention to in order to take effective actions and the ability to adapt and adjust when faced with new data and circumstances. So, again, I am suggesting that diagnosis might not apply to all organizational situations, but I do not think it is ruled out in all situations either.

Where this mind experiment of "what if" leads is perhaps the beginning of a contingency theory of diagnosis and OD. That is, under one set of conditions one might use a formal diagnostic step and under another set of conditions one might not. It could also include a mixed or blended approach that combined the two in some way or another, perhaps sequentially. This, of course, is a tricky business and it is difficult to be highly precise. With that caveat and given the above discussion, suppose we thought about two somewhat extreme conditions and the role of diagnosis in each.

Type I: An organization in a slow to moderately changing environment, with a limited set of stakeholders, confronting a more or less bounded and defined problem or deficiency, that is experiencing some but not immediate urgency, with a concerned but not fully committed leadership, who need a

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data-based or proven rationale for change. In terms of the Cynefin Framework for decision making this might be considered a Simple or Complicated situation (see Snowden & Boone, 2007).

Type II: An organization in a rapidly changing environment, with a complex array of stakeholders, confronting an unstructured and highly complex situation that has high urgency and requires new thinking and possibilities, with a fully committed leadership willing to endorse and actively participate in a more emergent process of discovery. In the Cynefin Framework this would likely be considered a Complex or Chaotic situation.

One might conjecture that a formal diagnostic step could be more applicable in the Type I, Simple-Complicated situation, whereas no formal diagnostic step might make sense in a Type II, Complex-Chaotic situation. These, of course, are conjectures based on a rough typology that does not capture the richness of organizational situations. But, it might be enough to suggest that it is time to move beyond the point and counterpoint discussion and seek a contingency-based discussion to guide practice going forward. Elsewhere my colleague Gervase Bushe and I have tried to start such a discussion by delineating what we describe as a bifurcation in contemporary OD practice leading to two forms of OD, one Diagnostic and the other Dialogic that eschews classic diagnostic premises and processes (Bushe and Marshak, 2009). In that discussion we mainly describe the differences and not how they might be reconciled or under what conditions each might be more or less applicable. Clearly that is a next step for researchers and practitioners alike to address.

My Concerns about the Current Controversy

Finally, I would like to add some thoughts and concerns as a longtime practitioner and educator about the current controversies involving diagnosis in OD. I worry about the denigration of the term diagnosis in OD practice not because the concerns raised above are ill-founded or inappropriate. They are not. I worry because they may seem to apply to many other aspects of the function of diagnosis broadly defined and as applied in practice. Here I am not talking about a formal diagnostic step that searches for organizational causes or underlying dynamics before pursuing some intervention. Instead I am raising the broader processes of discernment involved in trying to understand a situation before taking action. These processes perform similar functions to diagnosis, but might be called such other names as: assessing, scoping, sizing-up, judging, interpreting, evaluating, and so forth. For example, before I start the simple act of walking across a busy street I assess the situation. I check to see if there is any on-coming traffic, if there is a traffic light and if so what color it is, the width of the street and how long it might take me to cross it, whether there are others crossing at the same point and in the same direction, and so on. This happens in a moment, but is my learned diagnostic checklist of things to consider before deciding whether to wait or go ahead and cross the street . Furthermore I may even have variations on the basic model for use in London or New York. Similar diagnostic checklists both explicitly and implicitly inform my work as a consultant whenever I am assessing what is happening with the client system, if the leader seems supportive and committed, whether to proceed or devise a new approach, how to handle interactions in different phases of an engagement, and so on.

Whether we label this kind of professional practice as diagnostic or just a quick scan, it relies on similar basic competencies. In brief, it involves assessing a client situation and noting factors that some theory, model, checklist, or informed experience tells us we should pay attention to in order to determine how best to proceed. In this process we may or may not be searching for what we consider to be problems and their causes, but rather arriving at informed judgments about how best to proceed based on some type of data (facts, feelings, impressions, etc.) as processed through some personal and/or professional judgment schema. Consequently, whether we ever formally diagnose anything, we still need to assess, read, size-up, interpret, or otherwise make judgments and choices about clients and client situations from start to finish; and these judgments will be based on knowledge and skills similar to those used in diagnosis.

My concern, then, is that some OD practitioners may someday begin to think that there is no need to learn the extensive range of theories, models, and concepts that help one to understand and assess what is happening throughout an OD consulting engagement. These include, to name a few, theories and models of: leadership; change; organizational, team, and individual behavior; power, authority, and conflict; culture and diversity; methods of constructive engagement; and

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so forth. Suggesting in un-nuanced ways that diagnosis is not needed could lead to implicit misunderstandings that in OD one can simply contract to conduct a series of pre-defined steps in an orchestrated series of activities, and achieve superior results. That might in fact happen—although somehow never to me in my experience—but it leaves out critical aspects of what helps to shape success in OD. Consider the following few examples:

- Assessing a situation to see if it is a viable candidate for success.
- Making choices before, during, and after client contacts, activities, and events based on judgments about recurring or novel occurrences and interactions.
- Reflecting on what happened in order to up-date one's theory of practice and perhaps to share those insights and ideas with others via conference presentations, writings, or other means of professional information exchange.

What is needed given the current bifurcation of OD into diagnostic and dialogic approaches is more nuanced and agreed upon terminology for processes called by such names as diagnosis, inquiry, discovery, assessment, discernment, sensing, informed judgment, and so on. These terms are used by adherents to different OD approaches, but without common agreement as to if or when they should be used nor their meaning(s) in theory and practice. The consequence is discussions and debates within the OD community that sometimes seem to be comparing diagnostic apples and oranges. This is not helpful to anyone and especially to the advancement of the field.

In conclusion, then, I want OD practitioners to know what works, but also when and why things work so they can be master practitioners capable of knowledge-based innovations to the body of theory and practice called Organization Development. I do not care if they select work such that they never, always, or sometimes conduct a formal process of data gathering, diagnosis, feedback, and intervention in their practices, but very much want them to be able to size up a situation, read presenting dynamics, and scope what is needed in order to assess how best to proceed throughout the life of an OD engagement.

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