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Practicing in the Grey Area between Dialogic and Diagnostic Organization Development

Lessons from a Healthcare Case Study

By Yabome Gilpin-Jackson

Overview

The field of Organization Development (OD) continues to buzz with the excitement of its third-generation methodologies. These methodologies represent OD practices that are based on the premise that an organization or system already has positive examples of what they want more of or what is needed for a desired change. The premise of third generation OD methodologies is, therefore, to search out, highlight, or amplify what is already working in a system through genuine inquiry and conversation to understand varying perspectives. Examples of third generation methodologies include Appreciative Inquiry and various whole system engagement methodologies such as Future search or Open Space conferences that seek to unlock and amplify the generative potential in organizations. Third generation methodologies are distinguished from their first and second-generation precursors by the commitment to acknowledging and working with the subjectivity and meaning-making of all involved. It is an approach that upholds the social construction of human experience and embraces dialogue, inquiry, and an emergent process and approach to change (Bouckenooghe, 2010; Cameron, 2005).

At the opposite end of the spectrum, first-generation OD methodologies are based on the assumption that change can be orchestrated by objectively identifying and quantifying problems with a system or organization. Identified problems are then corrected with prescribed solutions

and recommendations that people in the system must adopt and implement. Traditional action research is the classic example of first-generation OD methodologies, where objective data or valid information is sought out and used as the basis for diagnosing deficiencies in a system and recommending solutions. Second-generation methodologies are the set of approaches that bridge the first and the third generations. They represent the developmental methodologies that built on action research to action science and learning organizations. The core tenet of second-generation methodologies is to work with observable data to identify discrepancies between desired and actual behaviors and outcomes. It involves a commitment to reflection and public analysis of attitudes, commitments, and behaviors that get in the way of desired outcomes, so that system learning can occur (Raelin, 2006).

OD practice has embraced its third generation methodologies. For example, there has been an explosion of whole system methodologies with features of third generation methodologies (Holman, Devane, & Cady, 2007a). As with any movement however, new challenges and complexities tend to underscore emergent opportunities. Bushe and Marshak have named a bifurcation in the field, defined by the move to the practice of Dialogic OD, which is characterized by the use of third-generation OD methodologies. They explain that the move to Dialogic OD remains unacknowledged in OD scholarship, as OD scholars continue to research and teach from the perspective

of conventional, traditional Diagnostic OD (Bushe, 2010; Bushe & Marshak, 2009).

Diagnostic OD is traditional OD practice in which a formal investigation is conducted so that objective data is collected and analyzed to make a diagnosis and recommendations for problem-solving—in effect, methodologies used in Diagnostic OD are likely to be first-generation methodologies. Second-generation methodologies arguably represent Diagnostic OD because of their reliance on using valid data to uncover discrepancies between desired and actual behaviors and outcomes. However, second-generation methodologies could represent Dialogic OD when identified gaps are addressed using dialogic interventions. For example, the practices associated with developing learning organizations often require the use of valid or verifiable data to engage in dialogue about discrepancies between espoused and actual behavior in organizations (Senge, 1990; Argyris, 2005).

One commentary in response to Bushe and Marshak (2009) noted and expanded on specific issues in the presentation of Diagnostic and Dialogic OD that raised a further question—can Diagnostic and Dialogic OD co-exist and be used as complementary forms of engagement in practice? (Oswick, 2009). In a recent debrief of a major healthcare project that involved all of the health authorities in the Lower Mainland of British Columbia, Canada, I found myself wrestling with this same question. The case in question was the Lower Mainland Consolidation of Medical Imaging in the healthcare system of British Columbia. In August 2009, the lower mainland consolidation strategy was identified for specific health services, including Medical and Diagnostic Imaging, as part of a strategy to manage spending and reduce growing healthcare costs. The goal of the program was to save $100 million through efficiency gains, while at the same time maintaining the quality of care and service levels to patients.

In this article, I use lessons from this case to describe two complexities associated with OD practice in the context of the tensions and balance between Dialogic and Diagnostic OD. The first relates to the dichotomous distinction being drawn between OD methodologies that define Dialogic and Diagnostic OD. The second is the challenge associated with focusing on the methodologies that define one form of OD to the exclusion of others. I use examples and illustrations to discuss how I and the team of OD practitioners working on this project experienced and addressed these issues. I conclude with a brief discussion of some implications for practice that arise from what we learned through this case.

sustained OD interventions, based on iterative cycles of data collection, analysis, and action to forward change with the client system (Bouckenooghe, 2010; Boyd & Bright, 2007; Rothwell & Sullivan, 2010). The distinction between AR as a methodology and AR as a process is significant because when viewed as a process, AR becomes a basis for practice and within each iterative AR cycle, any intervention can be used to forward change. Thus, Lewin's original AR model of analysis, planning, acting, observing, reflecting, and acting again, becomes the consulting

The art of mastering the grey zone in between Diagnostic and Dialogic OD becomes how well a practitioner can move along the continuum as appropriate to the circumstance. The crucial element becomes practitioners' ability to understand the orientations, philosophical basis, and intentions of the different forms of OD, such that they can effectively move between and switch their own mental models to practice effectively in either realm. This is not just a question of acquiring Diagnostic or Dialogic OD skills, but a matter of mastery such that practitioners can safely and effectively practice along the continuum.
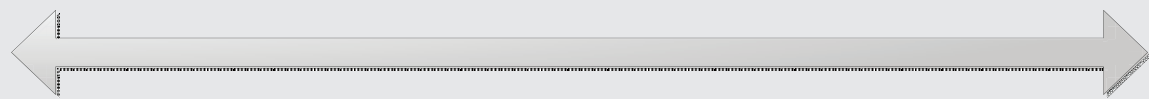
The Dichotomous Distinction of Methodologies

Bushe and Marshak (2009) describe well the divide between Dialogic and Diagnostic OD. In practice, this divide is articulated in the discourse surrounding OD methodologies. First and second-generation OD methodologies such as action research and action science are dubbed traditional methods, because they are used with a problem-solving lens. On the other hand, third-generation methodologies that represent Dialogic OD practice are associated with the future of OD (Rothwell & Sullivan, 2010). In the process, the fact that OD methodologies are often an approach as well as a process for OD practice tends to be lost. Hence, while action research (AR) for example is an approach and methodology from OD's first wave that might easily be labeled a diagnostic methodology, it is also a generic process for carrying out

model in itself. The focus here is less on diagnosis in order to present a prescriptive solution, but more on understanding the situation in order to take action to forward change and then reflecting on the impact of the actions in order to act again and so on (Wolf, Hanson, & Moir, 2011).

Therefore, when a process rather than a methodology-centered perspective is incorporated into OD practice, the dichotomy between methodologies diminishes and the possibility that there is a grey area and continuum in the space between Diagnostic OD and Dialogic OD emerges. While methodologies may be broadly categorized as one form of OD or the other, it is the nature of the practice and the intention behind the use of the methodology that would ultimately make it diagnostic versus a dialogic practice. If the intention behind a data collection tool like a survey for example is to support a

Table 1: Practicing in the Grey Zone of the Diagnostic to Dialogic OD Continuum

	Conventional Diagnostic OD	The Grey Zone	Conventional Dialogic OD
Type of OD Methodologies*	First-generation OD methodologies, e.g., action research.	First, second or third generation OD methodologies. Second-generation methodologies include features of Diagnostic & Dialogic OD.	Third-generation OD methodologies, e.g., Appreciative Inquiry.
Goal of OD program, process, approach, or inquiry**	Prescriptive diagnosis based on a biological metaphor of organizations. A focus on an ideal identified outcome.	A blend of diagnosis and dialogue as needed at different stages of the change process. A focus on effective change process to realize identified outcomes as well as potential.	Emergent self-organizing around a shared vision created in conversation and interaction. A focus on acting on opportunities and potential in the organization system.
Type of OD practice*	Methodology-centered where *diagnostic methods* define the OD program.	Holistic and adaptive practice that is responsive to emergent needs.	Methodology-centered where *dialogic methods* define the OD program.
Philosophical orientation to practice	Knowledge can be objectively discerned through research.	Knowledge is co-created through objective data and emergent subjective realities during the process.	Knowledge is emergent and constructed from real-time social interactions.
Role of OD Practitioner	Expert consultant.	An expert, collaborator, project member, facilitator, trainer, mediator, and other roles as situations demand.	Facilitator who recognizes that their presence influences knowledge creation.
Source of OD Interventions**	Interventions are recommended by the OD practitioner.	A blend of the practitioner's expert recommendations and self-organized solutions from organization members.	Interventions are co-created by all involved and especially through self-organizing.
Practitioner influence on implementation	Zero/limited influence where practitioners' role is limited to diagnosis or maximum influence where contracted to implement recommendations.	High influence at early stages where the emphasis is on diagnosis and zero to limited influence as the focus shifts to Dialogic OD.	Zero/limited influence—interventions are implemented through self-organization of participants.

*OD methodologies are the set of methods, tools, techniques, or defined processes used to inquire and/or take actions to improve an organization's effectiveness.

**OD program is a full cycle of research and actions taken to improve organization effectiveness.

***OD Practice is the professional exercise of organizational development using a variety of OD methodologies.

****OD Interventions are the action(s) and methodologies within an OD program.

practitioner to make expert judgments of an organization's health, because that data is held as objective and final, then it is a diagnostic tool used for Diagnostic OD practice. If the same data generated from the survey is used to facilitate inquiry and dialogue through which a change program is furthered from emergent ideas about varying and open interpretation of the data, a diagnostic tool has been used dialogically.

From a practitioner's standpoint therefore, the continuum from diagnostic to dialogic practice depends on how much one moves from expert on the diagnostic end of the spectrum to facilitator on the dialogic end of the spectrum. The art of mastering the grey zone in between Diagnostic and Dialogic OD becomes how well a practitioner can move along the continuum as appropriate to the circumstance. The crucial element becomes practitioners' ability to understand the orientations, philosophical basis, and intentions of the different forms of OD, such that they can effectively move between and switch their own mental models to practice effectively in either realm. This is not just a question of acquiring Diagnostic or Dialogic OD skills, but a matter of mastery such that practitioners can safely and effectively practice along the continuum. *Table 1* presents a summary of my proposals for practicing in the grey zone of the Diagnostic to Dialogic OD continuum, based on the lessons from the Medical Imaging case, which I describe further below.

The divide and discourse in Dialogic versus Diagnostic OD showed up

immediately in the case of the consolidation of Medical Imaging, during the launch meetings with the team of OD practitioners. The question of what form of OD we would practice was raised implicitly and explicitly as follows: what methodologies will we use to facilitate this change process? Would we be able to support the team to make the changes required if we took a diagnostic approach? How soon could we bring the whole system involved together using dialogic methodologies so that they could decide how to move forward with the consolidation mandate? There was a pull among the team to take a dialogic approach based on the current discourse in OD and experiences within the health authorities indicating that successful changes occurred where dialogic processes had been used to involve as many people as possible.

The reality, however was that little was known about the client system and so initial data collection and analysis was needed to determine a course of action, in effect a diagnostic approach using first-generation methodologies. After a set of fact-finding interviews, analysis and diagnosis, the recommendations were that the first level of intervention would be with the leadership team, before going out to the whole. Being a consolidated team themselves, it was decided that the leaders needed time for dialogue, decision-making, and team-building before any dialogic work with the whole system could be initiated. The recommended initial work was individual leader assessments followed by a series of five meetings to bring the group together over a six month period. The intention of these meetings was for the leadership to understand their own experiences as a consolidated team, work out how they wanted to be, and lead together through ongoing change across the whole.

The recommendations were made and agreed to through a classic Diagnostic OD consulting process of data collection, analysis, diagnosis, and a feedback meeting with the client where the recommendations were accepted. However, the recommended sessions were facilitated dialogically. For example, the design for each meeting was often emergent and adapted to the needs of the groups in real-time. Multiple perspectives and voices were encouraged in the meetings and facilitation processes based on inquiry were used to open conversations so that different perspectives could be openly discussed. Dialogue was the main facilitation tool used to support the group to arrive at their shared vision. The general thrust of all the exercises in the meetings was centered on how to create the future they wanted through engaging dialogue at their level and across the whole. Several first-generation and Diagnostic OD methodologies were used to generate data from the group about how they work together. However, that data was generated for the purpose of furthering conversation and was not held as the final truth on which to make decisions. Multiple interpretations of the data generated were invited, acknowledged, and considered by the group in determining how the data would influence their next steps. In these ways, a blend of diagnostic and dialogic methodologies was used. The facilitation team and the client made a specific commitment to engage in dialogic practice centered on inquiry, engagement, and an emergent process. This commitment was intentional in order to build the capacity of the Medical Imaging leaders and organization to use dialogic processes because the change they were experiencing was complex and continuous.

The Move to Methodology-Centered Practice

Closely associated with the dichotomous distinction of methodologies in OD's new wave is a focus on single-method OD practice. Increasingly, there is an assumption that inquiry that is not dialogic will not generate the engagement, self-organizing, and creative potential needed for transformational change. Correspondingly, there is a move towards practitioners that focus on particular third-generation dialogic methodologies. Bushe and Marshak (2009) do warn that tools should not be used to determine practice, but this is indeed taking hold when practitioners market to clients as "Appreciative Inquiry facilitators" or "Open Space facilitators" and so on, as opposed to Organization Development practitioners. The trend in practice is therefore for change leaders to seek out OD practitioners or facilitators to lead single third-generation methodology-centered events, without necessarily inviting them into the longer-term change effort the event supports. Client groups are then left to follow-up within their systems to sustain the self-organizing that is promoted and encouraged during the event. However, clients often do not have the time, skill, or capacity to do so. Thus, self-organized changes often fall away after the novelty and euphoria of the engagement event wears off.

There is, of course, the question of client-readiness to invest in long-term change efforts. However, the reality is that phenomena like sustained engagement and other soft organization effectiveness indicators predicated on human behavior do not happen overnight. The growth of methodology-centered OD practitioners, however, facilitates a short-term mentality and ability for change leaders to purchase piecemeal OD efforts, but this is not effective OD (Rothwell, Stavros, & Sullivan, 2010, p. 15).

In the case of Medical Imaging, you will recall one of the questions that arose early on was: How soon could we bring the whole system involved together using dialogic methodologies so that they could decide together how to move forward with the consolidation mandate? This question arose in part because of the OD team's commitment to practice dialogically in order to encourage optimal engagement and self-organization across the system. The team had been intentionally trained and supported in the practice of dialogic processes like Appreciative Inquiry, Conferencing, and other whole system OD methodologies. However, it was apparent after the first few meetings that the leadership and organization members were not yet ready for a large-scale dialogic process, because the foundations for dialogue did not even exist. Employees expressed distrust for leadership and the idea of a Dialogic OD practice through large-scale engagement was not initially welcomed. Employees felt that any dialogic process would not be genuine engagement,

but rather another attempt to impose health ministry and leadership mandated changes. The leadership team also needed to make agreements about how to engage the organization while balancing the reality of ministry mandates. In addition, the OD team's design and debrief conversations brought the conclusion that to lead with the question of methodology was to put form of practice before context. This meant putting a solution forward regardless of the situation, thus creating a prescriptive scenario for dialogic methodologies, which is one of the critiques of Diagnostic OD.

The team concluded that it was best to hold an adaptive and holistic orientation to practice, to ensure sustainable change in the context of a complex human system. We saw holistic and adaptive practice as OD efforts that are long-range and focused on all levels in a system—individual, team, and system-wide. In addition, it is practice that is responsive to the inter-level dynamics of the system as they emerge (Bouckenooghe, 2010; Coghlan, 2000). This requires knowledge and understanding of OD in all its waves, including diagnostic and dialogic methodologies, such that the right intervention is shifted to at the right time to facilitate the required changes. Practitioners need to be able to articulate and present these issues to clients in ways they can understand and accept, or else be clear that a single event, no matter how transformational the experience, is insufficient to sustain change.

In the Medical Imaging case, the context shifted over the year that the initial work with the leaders ensued. The leaders became increasingly aware of the positive impacts of their own dialogic conversations. They noticed that their own engagement increased when they focused on uncovering meanings they each attributed to the consolidation. They noticed that they were able to move forward simply by having the conversations that mattered, which they defined for themselves in the sessions. Through this process, they recognized ways in which the next levels of leaders were not being engaged. Correspondingly, staff feedback showed growing discontent. The context was now right for whole system engagement which was introduced

as a pilot with two sites where a team of approximately 14 leaders and 200 staff were experiencing compound changes.

The pilot whole system engagement included a series of staff meetings at each of the sites where the process was introduced and staff were asked about the future they wanted to create based on an Appreciative Inquiry intervention. The impact of the multiple changes and the transition was also acknowledged at these meetings, which gave staff the opportunity to express and address their ongoing concerns with the leaders. Classic AR interventions in the Diagnostic OD tradition were used to generate data that formed the basis for dialogue. All staff were then invited to two conferences that were facilitated using a variety of whole system dialogic interventions including Appreciative Inquiry and the Axelrod Conference Model.

The pilot whole system engagement was successful from all the evidence. At the end of the conferences, participants spontaneously wrote a poem to articulate the experience (see *Figure 2*), a testament to the success of the dialogic interventions in engaging the whole system. The Director for the sites gave the following written feedback:
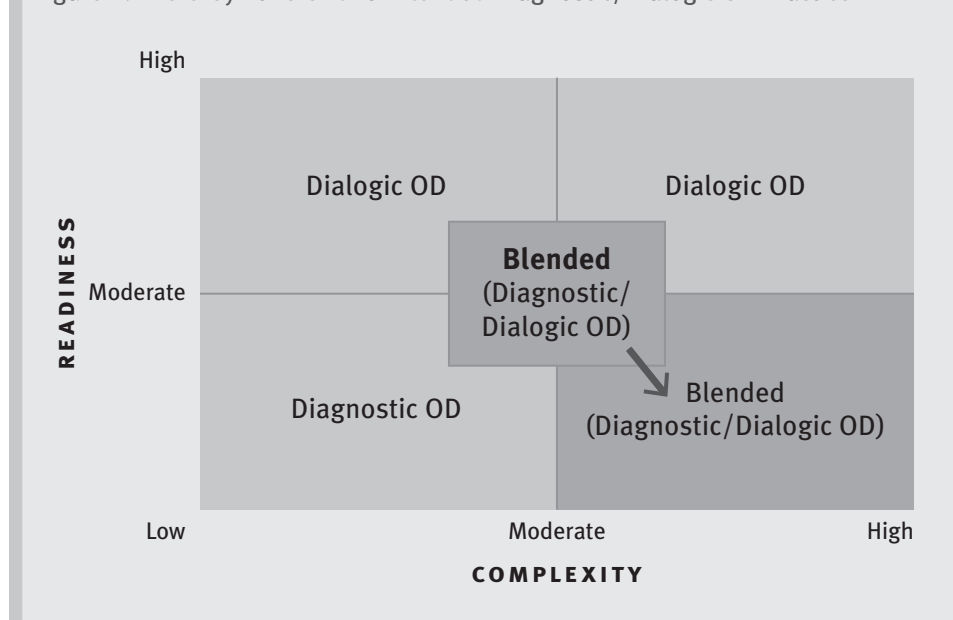
> The experience was off the scale for me and the benefits and changes that we are seeing and feeling - they are evident, palpable and visible in all of the modalities and staff conversations. It's amazing how contagious a smile can be and the affect it has on everyone. I am so thankful for the opportunity and experience with all MI staff. It was draining and emotional but sooooo worth it. (Director)

The qualitative process evaluation revealed the following themes of participants' experience: (1) increased connection to each other, leaders, and the whole; (2) sense of shared vision; (3) increased felt responsibility for own and team engagement; and (4) desire for continued action and annual/bi-annual all-staff conferences. Furthermore, change was realized within the organization and back at work through self-organizing. Each of the staff teams made simple commitments to take actions that would improve how they work together and support the consolidation changes. Within six weeks of the first conference, every team had voluntarily implemented at least one, and for some teams all of the actions they agreed to.

Thus, the dialogic processes of the conference that included principles of Appreciative Inquiry and the Conference Model followed the initial work and staff meetings, which were based on a mixture of diagnostic and dialogic methodologies. In the debrief of the project with the client and the facilitation team, it was agreed that the whole system dialogic intervention would not have been successful without the initial blend of Diagnostic and Dialogic OD interventions that set the foundation for the work. The initial diagnostic

The trend in practice is therefore for change leaders to seek out OD practitioners or facilitators to lead single third-generation methodology-centered events, without necessarily inviting them into the longer-term change effort the event supports. Client groups are then left to follow-up within their systems to sustain the self-organizing that is promoted and encouraged during the event. However, clients often do not have the time, skill, or capacity to do so and thus self-organized changes often fall away after the novelty and euphoria of the engagement event wears off.

Figure 1: The Grey Zone Grid for Blended Diagnostic/Dialogic OD Practice

the emergent and unpredictable nature of the process and outcomes associated with this approach. Dialogic practice requires a foundation of trust from organizational members that self-organization is acceptable. Furthermore, leaders must be willing to give up control of the change process and outcomes because any attempt to control these once Dialogic OD work starts will undermine the process and erode trust. Where readiness is low, dialogic processes in the experience of this case were met with cynicism. In addition, where the change complexity is high, defined by a context where there are multiple vested parties and variables to consider, Dialogic OD is more likely to lead to change that sustains in the long-term. Thus, in the context of high complexity and low readiness as in the Medical Imaging case, a blended approach where Diagnostic OD methodologies are used with dialogic facilitation and principles creates a foundation of trust and openness for subsequent dialogic practice.

As organizational readiness for dialogic practice increases, a fully dialogic approach can be consistently used as it becomes standard practice and the cultural norm for addressing change, regardless of the level of complexity of the change. However, where readiness is low and the complexity of the situation is also low with well-defined variables and a low number of impacted parties, a Diagnostic OD process is most appropriate.

intervention resulted in data being generated and played back to the system as a common foundation for ensuing dialogue. The small group conversations at the leadership and staff meetings that were then encouraged using dialogic interventions and facilitation served two purposes. First, it moved the groups forward in their planning and implementing of the changes. Second, it gave leaders and staff an opportunity to experience Dialogic OD and assess for themselves the value and impact of engaging in this way. As such, it created openness in the client system for large scale engagement and dialogue as the basis for implementing ongoing consolidation changes.

The client agreed that given the history of limited Dialogic OD practice in a system that was philosophically biased to diagnosis and measurement, any attempt to start initially with dialogic interventions would have been perceived as touchy-feely and would have failed. The blending of interventions and methodologies was crucial to the success of the OD work and the subsequent dialogic interventions in particular. The long-term focus and sequence of interventions was also critical to the progress that was made—A single event would not have accomplished the same level of momentum. In the words of the Executive Director and Consolidation Lead, "given the opportunity to lead the consolidation of Medical Imaging again, the only thing I would do differently is start the

foundational OD work and whole system engagement earlier."

Implications for Practice

The key learning from the Medical Imaging case in advancing the practice of Dialogic OD is that it is possible to blend and have diagnostic and dialogic methodologies co-exist. Furthermore, Diagnostic OD can be used as a lead-in to the practice of Dialogic OD, based on the assumption that Diagnostic OD generally reflects the objectivity and data-oriented perspectives in most organizations. Setting the foundation for dialogic practice can be accomplished by engaging in dialogic facilitation; in effect, using Diagnostic OD tools to initiate dialogic conversations.

Two key questions must be answered to determine whether a situation requires a blended diagnostic/dialogic practice in the grey zone. What is the level of complexity of the case? What is the level of readiness of the organization for dialogic practice? *Figure 1* presents a grid outlining how OD practice might be adjusted based on the dimensions of complexity and readiness. In particular, from what we have learned from this case, a blended approach is most appropriate for situations in the grey zone where the level of complexity is moderate to high, but there is moderate to low readiness for dialogic practice. A high degree of leadership and organizational readiness is crucial for dialogic practice because of

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Figure 2: Poem Spontaneously Developed by Medical Imaging Staff at the Pilot Whole System Engagement