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Practicing in the Grey Area Between Dialogic and Diagnostic Organization Development

Lessons from *Another* Healthcare Case Study

By Yabome Gilpin-Jackson with Melissa Crump

In 2013, the Practicing in the Grey Zone article was published outlining how Organization Development's third generation methodologies, that are anchored in social constructivist thinking and respond to our current complex systems, ushered in the era of Dialogic OD. Since then, the literature and exploration of Dialogic OD has expanded, most notably with the book D*ialogic Organization Development: The Theory and Practice of Transformational Change* of which I was a contributing author. In that volume and in their other writings, Marshak and Bushe generally define Dialogic OD as a mindset and practice of Organization Development through which practitioners design and facilitate inquiry-based processes that rely on shared meaning-making to result in transformational change. The transformational change unfolds due to the occurrence of core processes of disruptive emergence, generativity, and change in core narrative(s) underlying the dialogic processes (Bushe & Marshak, 2015).

Practicing in the Grey Zone discussed the implications of working from a Dialogic OD mindset, along the continuum of diagnostic to dialogic methodologies used in the field. This sequel presents another case study in which working in the grey zone was successfully addressed to achieve positive outcomes. We (lead consultants, Melissa Crump and I), describe our navigating and balancing of practice in the grey zone via the Dialogic OD consulting stages of initiating the inquiry, facilitating the journey, and sustaining the transformation (Gilpin-Jackson, 2015).

We start by reprinting an excerpt from the overview of the 2013 article, outlining the evolution and maturity of OD methodologies, leading to the delineation of the grey zone continuum. We then include a summary of the takeaways from the 2013 article before introducing the current case.

Overview, an Excerpt from the ODP Archives, V45(1)

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 assume 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, 2007). 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 using 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 (Argyris, 2005; Senge, 1990).

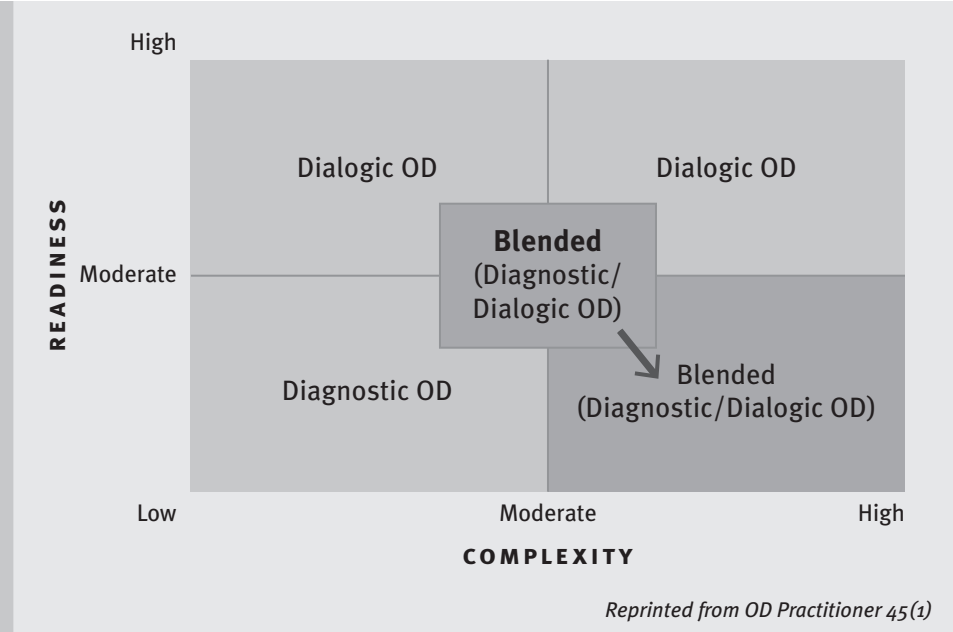


Figure 1. The Grey Zone Grid for Blended Diagnostic/Dialogic OD Practice

Lessons from the 2013 Case Study

The 2013 case focused on responding to the specific question: can diagnostic and dialogic OD co-exist and be used as complementary forms of engagement in practice? (Oswick, 2009). Through an analysis of a major healthcare project that involved all the health authorities in the Lower Mainland of British Columbia, Canada, the following conclusions were presented:

1. A dichotomous distinction between the generation of methodologies may not be necessary, because: 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.
2. 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.
3. It is possible to blend and have diagnostic and dialogic methodologies co-exist.
4. 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? (See *Figure 1.*)

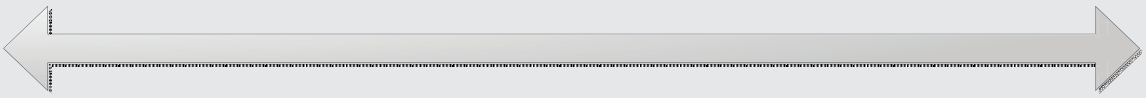
Table 1 was also presented to summarize the grey zone continuum.

A Recent Case

Royal Columbian Hospital (RCH) is a 402-bed tertiary care hospital in the Fraser Valley of British Columbia known for trauma, neurosurgery, cardiac, and neonatal care (Royal Columbian Hospital, 2018). Currently, approximately 385 physicians work at RCH comprised of approximately 150 family physicians and 235 specialists (Royal Columbian Hospital ER, 2018). RCH participates in the National Surgical Quality Improvement Program (NSQIP), a program created by surgeons for surgeons. This program is a risk adjusted, outcomes-based program to measure and improve the quality of surgical care through the generation of reports that help to inform decisions (American College of Surgeons, 2018).

RCH has had a mature NSQIP program, existing for over ten years. However, within those years there had been no change in the NSQIP data collected. The

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.

Reprinted from OD Practitioner 45(1)

data showed that the majority of the surgical indicators were categorized as "needs improvement," which is highlighted in red.

Organization Development was approached by the NSQIP surgical champion with these findings and the request was to partner with NSQIP to support their goal of getting RCH surgical staff involved in quality improvement. However, prior to approaching Organization Development, RCH and NSQIP had a Surgical Quality Improvement (QI) day planned for February 2016 to which they invited individuals from various surgical areas, as well as support staff. The agenda was traditional and content heavy, as well as having many physician focused presentations. Despite this traditional approach already being in place, Yabome Gilpin-Jackson approved the request for support and Melissa Crump as lead Organization Development consultant facilitated one portion of the day. The feedback received surpassed all other presentations. It was based on this feedback that enabled the NSQIP surgical core team to decide that their traditional approach could benefit from a different approach to change.

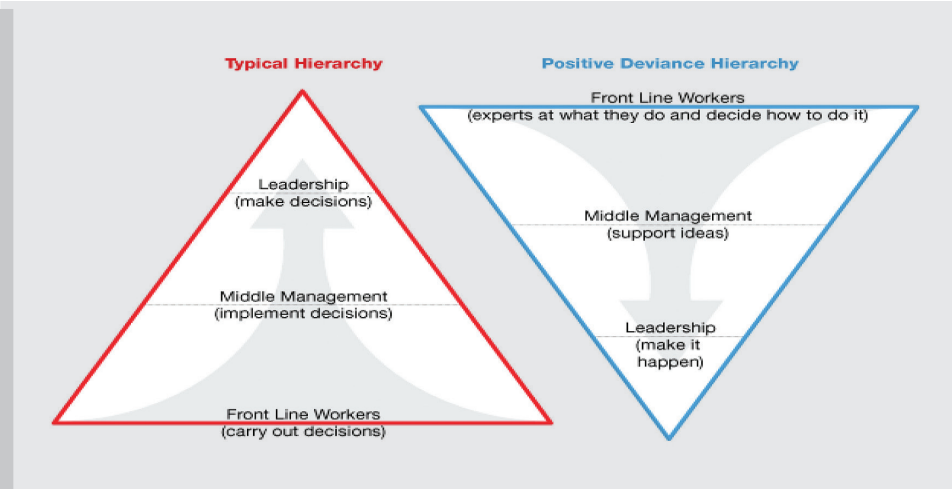


Figure 2. Flipping from Typical Hierarchy to Positive Deviance Hierarchy

Initiating the Inquiry

Although Organization Development was approached to support the change that was desired from this group, the overall mindset was still one that was traditional. In other words, a diagnostic approach was one that was familiar and used by this group and expected by the NSQIP surgical core team to be utilized in this intervention. However, upon assessment and because the level of complexity was high, and the first conference had created some readiness, a blended diagnostic/dialogical model was required for any shifts to occur. More specifically a multilayer and faceted approach was necessary for this intervention with RCH. Three levels of intervention were focused on for the first phase of the change intervention. Those layers included the senior leaders, the surgical core group and the point of care staff. Point of care staff was at this point expanded beyond physicians to all point of care staff. This shift is paramount from the ideology that NSQIP was originally surgeon focused, to one that encapsulates all those individuals that 'touch' the patient.

Each intervention was specific to each group, as well as carried out in a way that achieved the desired outcomes, even if the group was not aware of the intervention. The overarching methodology used was the behavior science and social change approach called Positive Deviance (PD). The PD ideology is "based on the observation that in every community there are certain individuals or groups whose uncommon behaviors and strategies enable them to find better solutions to problems than their peers, while having access to the same resources and facing similar or worst challenges" (Positive Deviance Initiative, 2017). PD relies on self-organizing in ways that enables generativity and emergent solutions for complex challenges. The self-organizing methodologies commonly used with PD are called Liberating Structures (LS) because they liberate all to participate. These methodologies meet all the criterion for dialogic OD methodologies. The focus in this phase was to introduce tools and models found in LS to enable creative destruction, as well as prepare the client groups by demystify some of the self-limiting behaviors and patterns that are inherent in the group.

Positive Deviance was used at all three levels of interventions. The first being with senior leadership and surgical core group. A shift in their mindset and orientation to the work was essential to the success of staff. There was a need to move from the traditional hierarchical model to one that flips it upside down and essentially inside out, where the role of leadership is to support the ideas that emerge from staff instead of making decisions. Some may say leaders need to make decisions and there is no disputing that, however when achieving sustainable long-term change to socially rooted behaviors, we must ask the controversial question: "How is that working for us?" There can be a balance where leaders provide the minimum specifications needed in a change, however successful change is one owned by those carrying it out. See *Figure 2* adapted from Arvind Singhal (2017) presentation. As the literature has also confirmed, OD thrives to support complex adaptive change when leaders manage the process, but stakeholders define the changes required (Bushe, 2017).

This new way of thinking was also required for the staff to own this new way of working towards quality improvement. While working with senior leadership and the surgical core team, point of care staff were invited twice a year to emersion workshops, and subsequently to what became an annual conference. The workshops were emergent and co-created by the Organization Development consultant and the NSQIP surgical core team with input from the staff. Each workshop built upon the needs of the organization, site and staff, while enabling staff to learn about Positive Deviance and utilize Liberating Structures to problem solve around their quality improvement challenges. But more importantly, it was a time for staff to connect to the work and each other and see things and each other in a different light. "Flipping" your thinking was the first PD ideology taught. We were not only looking

at the possible verses the impossible, but we are also looking at each other differently by creating connections and fanning similarities. When that mindset is encouraged staff do not look at what is not available but what and who is available. This alone was a huge achievement as many changes that are necessary to improve quality improvement start with resources and changes that are readily available and within their reach or control.

As simple as the above may sound—it is, and it is not. Change first takes time, persistence and most of all commitment.

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The methodology requires actively working at all three levels consistently and simultaneously, as each influences the other. It requires listening to the system to constantly adapt and change as the system changes and evolves. Most of all it requires creating the conditions for change that does not feel "hard" or uncomfortable for those involved in it. It requires individual leader coaching, strong facilitation design for the workshops, and consistent collaboration throughout.

Facilitating the Journey

The annual conference became the core avenue for facilitating the required transformations at scale, where all three groups came together to generate new learnings and solutions across the spectrum of NSQIP challenges. The annual conference focused on three segments: a) educational component, b) sharing the work by staff at RCH, and c) opportunity to continue the work in the room. From a transformative learning perspective, the conference became a space for the groups to explore and share options for being and working together that the emerging solutions required of them. They recognized the shared needs and desires and together they planned accordingly (Gilpin-Jackson, 2015).

Our observation of the first year and a half was that individuals both on the core NSQIP planning team and staff did not necessarily understand the changes occurring. In leading the design of the change from a dialogic mindset, both structured dialogic processes such as PD/LS and process dialogic consulting, i.e. direct/formal and indirect/informal inquiry, and conversations were used by the OD team to engage in ongoing meaning-making, planning, and change (Bushe & Marshak, 2015). Every conversation was considered a change intervention. So, while the emergent nature was being tracked in the mind of the consultant, it sometimes seemed unstructured and chaotic in the minds of the core group. The consultant then took on the role of reducing the client's anxiety, thereby moving them further along in understanding their roles in change and what they were experiencing (Marshak, 2016).

The development of the content for workshops seemed random and unstructured, however the emergence of the content was very structured within liberating structures. The workshop themselves built upon each other to be responsive to the needs of the staff and the system. The core team, once socialized to the new model of change and mindset, were able to co-facilitate. As processes and outcomes started making sense, participants started to try to "figure out" the pattern of what was happening and how it was happening. For example, when individuals experienced the workshop they started to express that they too can build the workshop with Liberating Structures model and tools designed together as well as connection activities that got people thinking about the content. This was positive from the perspective of getting people to this point of a developmental mindset. However, applied behavioral methodology isn't about "figuring out" the secret ingredient but is about knowing that in each recipe the secret ingredient needs to change in response to the people involved and situation at hand. The secret ingredient does not lie in the hands of one "expert" person or in one "perfect" process. This was demonstrated when the organization development consultant was away and the group was tasked with organizing a workshop on their own. After trying to figure out the "secret sauce" they defaulted back to the traditional way of doing things with highlights from what they had been learning. The experience of this workshop provided the group with a different perspective that allowed them to recognize the intricacies and nuances that change work with a dialogic OD mindset entails and the essential components that they needed to attend to. It also was the best demonstration to the team of the value of continuing to build their own capacity to work from a dialogic mindset going forward.

Sustaining the Transformation

The NSQIP data was being monitored throughout this intervention and if you recall it had not changed in ten years. After 1.5 years of NSQIP working in partnership with Organization Development 85

of the 100 indicators measured by NSQIP had moved to either 'exceptional' or 'as expected' metric (ACS Annual report, 2016). The data sheet was no longer painted red as it was prior to the intervention. More specifically this meant that there was an 85% reduction in morbidity across all indicators and all programs. This change has never been seen before.

This change in data allowed for senior leaders to see the value in the work the NSQIP surgical core team was doing with Organization Development. Those that were in denial that "this work" actually worked were no longer in denial. Staff also were able to see their impact on the NSQIP outcomes that were measured and as a result were actively asking for their data. Partnerships between support staff like infection control and prevention were cultivated and physician's ears were perking up to the possibility of quality improvement at RCH.

RCH had its third annual conference this year that looked and felt very different to the first and even the second one. The conference moved away from the NSQIP-driven premise. Although the data is still a measure for change, the conference was all encompassing of quality improvement at a site level—the whole RCH was invited to the quality improvement day. Although there were two guest speakers, the highlight was the rapid-fire presentations where staff at RCH shared the quality improvement work they participated in. The core group that started out solely NSQIP focused, has emerged into one that is truly multidisciplinary with representation from across the hospital. They even noted that since their focus has changed their name must also represent the change. They are now called the Quality Improvement League.

As the hope of all Organization Development consultants is to work themselves out of a job we can safely say we have done that. The group is mature enough and has the basic foundations that has allowed us to step away and let it emerge and morph into what it needs to be. However, we are also aware that sustaining changes from dialogic OD processes is often difficult if sustaining structures to support ongoing dialogue, planning and integration are not put in place (Roehrig, Schwendenwein, & Bushe, 2015). We are now transitioning the work to a site-based consultant who will loosely hold this group and guide them as they develop fully. Consultation will continue with the authors if/as needed to design ways to amplify and embed the changes and fan the continued spread and scale of dialogic OD practices across the site. The forums for continued follow-up, integration and tracking of outcomes have already been instituted through the periodic workshops and annual conference.

Conclusion

I made the case recently that for OD practitioners to grow what we want more of we must focus on OD as the *application* of the behavioral and social sciences to develop groups of people from *where they are to where they want to go* through *high-engagement and high-inquiry processes* (Gilpin-Jackson, 2018). I argued that OD practitioners might consider the following six conditions to amplify our influence. This case study met all the criteria as follows:

1. **Claim unique value and space** of supporting development in organizations and practicing OD such that: "methodologies need to be used holarchically, where one flows into the other as we nimbly switch between them as needed, versus as an either/or." This was certainly what happened in this case as the lead consultant Melissa Crump switched between methodological orientations to meet clients where they were initially within a dialogic framework, then focusing on creating a dialogic mindset and learning transformation as the next step, and subsequently leading the group to whole-scale dialogic practices.
2. **Expand OD practice domain to work at full scope.** One way I proposed that we do that was that we would better engage the wisdom and power of the crowd to galvanize leadership support for required systems changes. This was the predominant orientation of this case study.
3. **Return to the values-base of our field.** I asked: How might we be persistent in practicing these values in ways that allow them to grow? Positive Deviance and Liberating Structures were listed as one of the exemplars of thriving dialogic OD practices enabling this.
4. **Build and share portfolios of cases and research.** I foreshadowed this case now outlined here as an example of a case study that had achieved desired results based on the continuum of OD practice. Our client-sponsor has also been profiled elsewhere for his leadership in this case as well as received an organizational award as a result (O'Conner, 2017)
5. **Forge new partnerships**: Quality Improvement was listed as a discipline where practicing OD could thrive because of the complex adaptive challenges facing today's healthcare.
6. **Engage in disruptive practice:** As has been described, the process engaged in was certainly a disruption from the traditional diagnostic orientation the client was initial most comfortable with.

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