"TOO MANY CONSULTANTS FAIL BECAUSE THEY EXPECT THE CLIENT TO START WHERE THE CONSULTANT IS IN TERMS OF TECHNIQUE AND APPROACH."

CONSULTING APPROACHES: TWO BASIC STYLES

BY WILLIAM B. CASH AND ROBERT L. MINTER

Many writers in the field of organization development advocate the utilization of the "process-consultation model" with clients as a more effective strategy than employing the "doctor-patient model." As full time practicing managers, credentialed consultants, and pragmatists, we are not in total agreement with this "either/or" concept prevailing in literature. In our opinion, each consulting approach has its place depending on situational factors.

As we view these two basic models of consulting, the process-consultation model is highly dependent on group involvement and participation by members of the client system in the diagnostic and problem-solving stages. With the doctor-patient model, the consultant usually diagnoses what the client's problem is and proposes a solution with minimal involvement of the client or work group. Each model contains its own set of assumptions made of the client and consultant, such as:

Process-Consultation Model
— Assumptions —

- The client and consultant jointly diagnose the problem.
- The consultant's role is to train the client in using diagnostic and problem solving techniques.
- The client has the major responsibility to develop his/her own solution and action plan to the problem.
- Problem solving is more effective when the client identifies what processes need to be improved (e.g., reporting relationship, reward system, organizational structure).
- The client has more knowledge and insight about what will work in the organization than does the consultant.
- The client has more of a commitment for implementing the action plan if involved in the entire diagnostic problem solving phases.

Doctor-Patient Model
— Assumptions —

- The consultant is hired to identify the problem, diagnose it, and recommend a solution.
- The consultant has more expertise regarding the specific problem than does the client.
- The consultant is not expected by management to train the client in diagnostic and problem solving skills.
- The client expects the consultant to solve the problem in a relatively short period of time with minimal disruption and involvement of the work force.
- The client can be just as committed to implement the recommended solution and to follow-up on its progress if the procedures and reward structure for doing so exists.

Whatever assumptions the client and consultant subscribe to, they must discuss them to develop the appropriate psychological contract and role expectations each has of the other. Although we subscribe to the process-consultation model in theory, we have discovered that the consultant should start where the client is in terms of "readiness" for certain consulting approaches.

Our experiences have indicated that clients within a single organization can have various degrees of sophistication and "readiness" for

either the process-consultation or the doctor-patient approach. To say one should use process-consultation rather than doctor-patient consultation with clients, in our opinion, is not based on organizational reality. The consultant should be extremely careful not to commit to a psychological contract or set of role expectations with the client which the organizational environment cannot support. Client readiness for specific consulting approaches is extremely important.

The appropriate consulting style used with the client should be determined by analyzing situational conditions that exist. Using situational analysis as a basis for determining what contingencies should be considered allowed, we believe, for both parties to be more genuine in laying their cards on the table. Often consultants are used to fixing the blame for what went wrong and consultants are sometimes seen as selling back to the client their own solutions.

The process-consultation model presupposes certain ideal conditions that must exist for the consultant to be effective. In a way, process-consultation is more limiting than the doctor-patient approach because of the number of preconditions that must be satisfied prior to consulting. The doctor-patient strategy does not make as many predemands of the client.

Listed in Figure 1 are what we consider to be the ideal preconditions or "readiness" criteria for the process-consultation model to be effective when working with clients.

FIGURE 1.

PROCESS CONSULTATION — CLIENT "READINESS" CRITERIA

	Yes	No
1. The client has appropriate problem solving skills required for joint diagnosis with the consultant and others.	____	____
2. The client perceives the need for improvement.	____	____
3. The client is problem solving oriented (rather than solutions oriented).	____	____
4. The client is willing to learn from the consultant and work group by going through diagnostic problem solving phases.	____	____
5. The client wants to help in solving the problem.	____	____
6. The client is interested in an "original" rather than a prescriptive solution.	____	____
7. The client will permit the consultant to learn about the work climate through on location observation, discussions with employees, review of confidential files, etc.	____	____
8. The client and consultant are able to interact effectively at the interpersonal level.	____	____
9. The client and consultant agree that the problem is worth solving.	____	____
10. The problem has high priority with the client.	____	____
11. The client desires to be actively involved in diagnostic phases of the problem solving process.	____	____
12. The client is willing to commit additional resources (within reason) to aid the consultant in the fact-gathering and diagnostic stages.	____	____
13. The client is trainable (i.e., the consultant feels that the client can, wants to, and has the time to be trained) in using diagnostic problem solving tools.	____	____
14. The client is open to innovative problem solving approaches.	____	____
15. The client is willing to work with feedback survey data (such as interview data, or questionnaire data) collected by the consultant.	____	____
16. The client has a high risk orientation relative to identifying and solving problems through the utilization of participation techniques with his/her work force.	____	____
17. The client is supportive of vertical team building approaches.	____	____
18. The client is willing to implement mutually agreed upon solutions and action plans.	____	____
19. The solutions are not obvious to the consultant based on past experiences with other clients. Diagnostic work is necessary.	____	____
20. The client and consultant will not be violating professional ethics, laws or morals.	____	____

"Time" is Important

One other factor, while important, is certainly not critical and that is the time available to each. The process-consultation takes time while the doctor-patient approach can be rather brief. Many consultants make decisions by calibrating their intestines or relying on what was successful in their last consulting job. We have some key items which we believe are signs of readiness or reluctance to move on to the process approach.

Item one and two are fundamental to process consultation. With these two in place, the doctor-patient model may be appropriate. Seven and 15 are also weighted very heavily in our thinking. The collecting and exploring of data is absolutely essential to making progress when using the process-consultation approach.

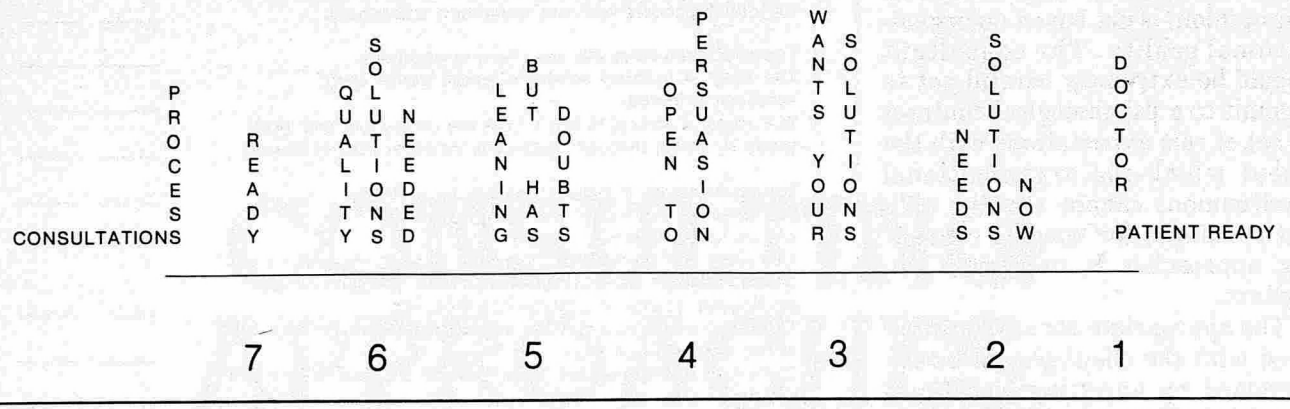
One method which can be taken in using the checklist is if you are using the team approach. Have each member of the team do a simple yes/no and then compare the results. A second method which can be deceiving but may also be used is a seven-point scale (Figure 2).

When using a seven point scale do not be lulled into a sense of scientific security. There is no magic number of "readiness criteria" that need to be met before one decides to use a particular consulting style. However, we have discovered that with some clients the doctor-patient model is an appropriate starting point, and can — over a period of time, create the "readiness" conditions necessary to implement sophisticated process-consultation strategies with clients. Timing is extremely important when employing the appropriate consulting style.

We have observed that some of our clients have improved their organizational and interpersonal effectiveness under the doctor-patient approach. Using process-consultation strategies with these particular clients would have probably resulted in failure because they did not have an appropriate readiness profile. On the other hand, there are a number of clients we have worked with who required process-consultation because of their readiness for such a

Figure 2.

SEVEN POINT READINESS SCALE



strategy — to use a doctor-patient approach would have also resulted in failure. We frequently get the feeling that too many consultants have been brainwashed in implementing ivory tower participative approaches with clients without thinking about client readiness for such sophisticated and demanding techniques.

Further research is required to determine weighting factors for each of these conditions. Perhaps you may want to weigh the importance of each condition based on your own experiences. Determining a weighting system would certainly aid the consultant in evaluating client readiness for a particular style.

Our major point is that a consultant must start where the client is! Too many consultants fail because they expect the client to start where the consultant is in terms of technique and approach. This can easily lead to failure. Prior to your next consulting assignment you should use the "Readiness Criteria" checklist, along with any additions of your own, to analyze the environment in which you will have to consult. After assessing your client with the checklist, ask yourself what consultation model or style you should have.

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