COMPELLING STORIES AND MULTIPLE CHANGE NARRATIVES: THE CASE OF REMOTE MATERNITY SERVICES IN SCOTLAND

Patrick Dawson*
University of Wollongong, School of Management and Marketing, Australia
and University of Aberdeen, Business School, United Kingdom
Email: patrickd@uow.edu.au and p.dawson@abdn.ac.uk

Jane Farmer
UHI Millennium Institute, Centre for Rural Health
The Greenhouse, Beechwood Business Park
Inverness IV2 3BL, United Kingdom
Email: jane.farmer@uhi.ac.uk

Elizabeth Thomson
University of Aberdeen Business School,
Edward Wright Building, Dunbar Street
Aberdeen AB24 3QY, United Kingdom
Email: e.thomson@abdn.ac.uk

Preferred Steam: Steam 10, 12, 15.

Profile: Patrick Dawson holds a dual position as a Professor at the University of Aberdeen Business School (UABS) and as a Professor in the School of Management and Marketing at the University of Wollongong. He has published numerous articles and has a long research history in the area of organizational change where he has published a number of books including: Reshaping Change: A Processual Perspective, London, Routledge, 2003.

Keywords: change, stories, storytelling, maternity services, rural health, sustainability
COMPELLING STORIES AND MULTIPLE CHANGE NARRATIVES: THE CASE OF REMOTE MATERNITY SERVICES IN SCOTLAND

Abstract: This article examines the role of stories in the redesign of maternity services in remote areas of Scotland. From a longitudinal study of six separate sites data were collected on the lived experience of change and the significance of context and forms of involvement on individual and group attitudes and perceptions. Our focus here is on influence of stories in shaping change and the evaluations of change outcomes. Our essential argument is that compelling stories not only explain what happened in the past, they are able to shape our understanding of the present and influence how we act in the future. Respondent narratives provide the evidence base from which research narratives, causal inferences, and theories are generated. By explaining what happened, and anticipating what should happen next, accounts are post-hoc theories, and before-the-event determinants, with the potential to be causal factors in the ongoing change process. As such, the import of stories in mobilising public opinion, influencing government decision-making and steering processes of change should not be underestimated. Stories and storytelling remain powerful tools in legitimating public policy and local change initiatives.

Keywords: change, stories, storytelling, maternity services, rural health, sustainability

Introduction

This article reports on the findings from a study of six health care sites in remote and rural Scotland. Our central aim is to demonstrate the importance of change narratives to understanding processes and outcomes of change. We argue that a compelling story can be both a major driver for change and a major vehicle for resistance, and that change comprises multiple and ever-changing stories that emerge, are re-written, compete and variously shape and are shaped by those experiencing change. From our research into change in remote maternity services in Scotland, we illustrate the different type of accounts that can emerge from midwives, managers, local communities, policy documents and the media, and how these can shift in meaning and emotionality over time. This leads us to a position that is critical of monological accounts in calling for a greater accommodation of polyvocal narratives (Tsoukas and Hatch 2001). It also raises a number of methodological and research issues, such as:

- What is the role and influence of the researcher given that they need to break into these stories of change in order to collect material for analysis and presentation?
- How do we deal with conflicting data (accounts) in our fieldwork and what are the implications for research design, theoretical developments and our practical understanding of change?
- If there is no single authentic account of change, what are we doing as researchers in presenting a single version of events in our conventional case study write-ups?
Like many other researchers carrying out longitudinal fieldwork on change (see, Pettigrew 1990) we seek to cross-reference and validate data from multiple sources. In conducting case study research, triangulation through the use of different data sources is often used to validate and substantiate certain versions of event sequences over others. We argue, however, that the idea of plurivocality, which is viewed as an essential element of organizational discourse (Hardy et al 2005: 803), is often missing or underplayed in contextual case study write-ups of company change (Dawson 2003: 128-141). As such, we draw on elements of narrative theory in furthering our analysis of the role and place of stories in understanding change processes (see, Gabriel, 2000; Pentland 1999). We contend that one of the strengths of a narrative approach is that it gives explicit recognition that accuracy, in any ‘objective’ sense, is not possible because there will always be multiple and conflicting interpretations of change (Leitch and Davenport 2005).

Remote maternity services in Scotland

Our programme of research into remote maternity service provision sought to explore issues of managing change towards the achievement of new models of service. The study took place in the North of Scotland and the Scottish islands and all case study sites have been given pseudonyms as agreed at the outset of the research. A case study design was used and data were collected through a series of semi-structured interviews with staff and community informants as well as through non-participant observation, documentary review and a summary and analysis of media articles and reports. The study was longitudinal with data collection commencing January 2004 and being completed April 2005. Drawing on the processual approach, the majority of study participants were interviewed repeatedly. Interviews were conducted with the same staff and community representatives at three different stages during change, whilst managers responsible for the units were interviewed on one occasion. Taken as a whole, 135 of 147 planned interviews were conducted with staff, managers and community representatives and four visits were made to each of the six case sites in the collection of observational data. All but a few of the interviews were taped and later transcribed, producing a large body of qualitative data.

In analysing longitudinal case study data, transcriptions are transformed from a single text to multiple fragments (many with annotated commentaries) that are then combined and linked with other data in developing pre-assigned categories, and in creating and redefining others. In a way, the data is carefully laid open, it is examined, redefined, developed and recombined with other data, tagged and/or labelled and then reconstructed to form something quite different from the original text, in an attempt to explain and understand the object of study. The write up from this type of research and analysis takes the form of a case study (post-analytical descriptions) that tells the researcher’s tale of change. Although different perceptions and attitudes can be captured in these change stories, many
versions are absent as the author typically seeks to maintain some coherency to their analysis of change. In addition, the focus is generally on explaining the way individuals and groups shape change rather than on the way change stories are constructed and re-written to influence the processes they are describing. Thus we contend that by combining some of the insights of the narrative approach with contextual studies of change we can further our knowledge and understanding of processes of change. Central to this is our claim that change narratives lie both outside the process in providing explanatory accounts whilst also being a part of the process in shaping change.

**Towards new staffing models: policy formulation and community involvement**

The two main models that dominate in policy discussions centre around the notion of consultant and midwifery led units. For example, a report was published by the Expert Group on Acute Maternity Services (EGAMS) that stated that low risk women in remote areas could be catered for by local midwifery led units, while those at higher risk should use consultant led services at centralised specialised referral units. Although remote maternity units were being remodelled in line with this policy, a tie in with this position was never made by any of the managers in our study. The common notion behind the policy drive for change was the idea that all maternity services were working towards achieving a ‘sustainable’ service and in practice, this meant a move towards a greater role for midwives in local deliveries at remote units. Interestingly, this concept of ‘sustainability’ is highly prominent in health policy and provides useful ambiguity in sidestepping more contentious and politically sensitive issues of closure. Policy documents talk of remodelling, safety and appropriateness rather than explicitly advocating the shutting or removal of remote services to more centralised hubs. This focus - on how to remodel services to achieve sustainable practice – was the basis from which discussions with the local community occurred. A number of focus groups and meetings were held at various sites with varying success in turnout and participation. As one interviewee noted in respect to Duncanland:

> The attendance in Duncanland was very good, there was over 100 at that one, and that was an opportunity. All the sort of top people from the health board were up and they were giving their side of the story, if you like, about why they thought change was necessary and it gave the public the opportunity to ask questions. So they covered the county quite well and the thing was chaired independently and I thought that was excellent…As a result of these meetings things have moved on slightly, I wouldn’t say the public were convinced of the (changes proposed) but they seem to think there is another option that has presented itself as a result of these meetings (Health Councillor).

Most staff who commented thought that it was important to involve the public right at the start of thinking about redesign, not simply to consult them once decisions or options had been determined.
Although there is general agreement that the service model required for remote areas differs from metropolitan areas, there remains a ‘push’ for a common design that accommodates a centralised framework and mirrors the characteristics of a dominant service model. As a community representative from Stuartsle commented: ‘I mean its good because they get everybody involved, there’s doctors and nurses and midwives and users and health council and stuff, but I get the impression there’s an awful lot of discussion but maybe not a lot of action’.

Interviews with community members highlighted the import of these services to sustaining communities in remote areas and in making them attractive places to live. It was argued that running down such services would have a multiplier effect in making rural Scotland unattractive to younger people looking for working or lifestyle choices, and who were also thinking about starting a family. As one health councillor commented:

I would like to see Cameronisle, not only Cameronisle but any remote area having just a small unit that women could feel that they didn’t have to travel hundreds of miles to go and have their baby. I would not like to see the remote maternity services being centralised in some large unit that can be impersonal. I don’t want to be derogatory about the large unit because they have their role to play, but I am speaking very much as an islander and want to see a vibrant progressive community and to be able to sustain that type of community. I am maybe looking at it too broadly, but I think you must, you can go down to the specifics of your unit but you must look at the broader issues. And to be able to keep communities alive and vibrant then I think, you need to have a well-resourced maternity unit. (Health Councillor, Cameronisle)

From a central framework perspective, remote services are very costly to provide. In a simple economic sense, there are questions raised over maintaining their financial viability. However, the public voice is a useful vehicle for resisting the imposition of change from the NHS that proposes a story for the rationalisation and closure of remote expensive health provision. The public are able to use the media to get their ‘voice’ heard and to ensure that, like branch rail services before them (the Beeching cuts in the 1960s), remote services are not eroded. But with problems of recruitment and the tightening of budgets, concerns over service provision have also arisen among local staff. There is a level below which services are not sustainable in the sense that they may put patients in an ‘unacceptable risk’ position, especially in cases where clinical difficulties arise. On one side, there is a story based around efficiency, good financial management of the NHS, monitoring of costs, and regular reviews and evaluation of national health provision. From this perspective, many remote services appear prohibitively expensive given the scale of service they provide and the number of
patients they deal with. On the other side, is a view that if you are going to maintain services in remote and rural areas then you need to ensure that they are adequately resourced and not simply maintain an under-resourced service to prevent public and media outcry over the closure of local health facilities.

From these different change perspectives, we get a number of different accounts of what constitutes a sustainable maternity service in remote areas. From a national perspective, the preferred scenario is either to provide a less specialised service at lower overall cost (especially as generalist provision can provide a wide range of services at a certain level) or to close these local centres that are viewed to be prohibitively expensive. A potential way forward, is to ‘downgrade’ or close some centres and to use some of the resources released from this to further bolster others (a type of localised centralisation and rationalisation of services). From a local perspective, the preferred scenario is the development of fully resourced local services – that may require higher salaries to encourage skilled staff to work in these more remote areas – that can safely meet the needs of their local client base.

**A new model of sustainability: consultant and midwifery led units**

In the redesign of maternity services there were different experiences relayed by midwives and others on the place of consultant-led maternity units and midwifery-led facilities. For example, there were some concerns that midwives at consultant-led units would be reluctant to assume certain duties and skill areas if there was a move to a midwifery-led model of care, perhaps due to lack of confidence or belief that these skills areas were outside midwives’ professional remit. However our data was mixed with some respondents advocating that a movement away from consultant-led care was timely: ‘I feel the consultants are too dominant, that midwives don’t have enough autonomy in this unit. The consultants, I appreciate have to have guidelines, we have to, I am not saying I don’t want to follow their instructions but they use us like handmaids.’

Midwives at consultant-led units generally argued that it was women in the local community that wanted consultant-led models and that a change to a midwifery-led service would drive more women to have their babies at distant referral units. In contrast, midwives at the midwifery-led units felt that there was a demand for local deliveries and that good experiences relayed through the local community further supported such developments:

> We were compelled to increase the local delivery rate, home births in the unit. We thought it might take about a year to get the numbers up but in actual fact in the first six months it has gone up quite dramatically. The number of women who are choosing to deliver locally. And I suppose it’s just worked in nice if somebody has a delivery here, has a good experience and word of mouth in the community plus the midwives. I mean it’s a better service; the
midwives are focusing purely on the midwifery. They have got the time to spend with the women and are giving them the appropriate information to enable them to make choices.

(Lead Midwife, Buchanisle)

In the cases where external midwifery teams were charged with driving change, responses were generally positive. This contrasted with units run with GPs and obstetricians, where it was found that these health professionals were less willing to concede to decisions that arose from group discussions. Typically, obstetricians and GPs were resistant to suggested changes in areas where they viewed that their authority (expertise and views) should not be questioned. A loss of control in writing the script of change, of potential ways of doing things, threatened the power base of some and resulted in some rather aggressive encounters. As a Manager recounted: ‘Certainly the GP who was there who was quite angry about it just said, right actually sod this, I’m not wasting my time with it.’ And a midwife commented: ‘We had the [obstetrician] from [x] turn up who is or was, a very nice person. He really went for the jugular …I got quite angry about that…he was actually quite awful.’

In cases where midwives were involved, there was a high level of enthusiasm, especially in discussions that sought to make-sense of current ways of doing things in considering options for the future development of sustainable maternity services. Ambulance service personnel were also positive where they were involved in change processes. However, getting the involvement of GPs and obstetricians proved more problematic as their participation varied and was often associated with rather rude and aggressive behaviour at intervention sites. These individuals were not seen as unfriendly on a personal day-to-day basis, but in the context of developing and engaging in the shaping of a change narrative, they expected their position to be unquestioned and felt threatened by a movement of opinion (the emergence of new stories) that levelled the playing field in seeking sustainable scenarios and new potential courses of action for the delivery of remote health services.

The problem of limited resources was a recurrent theme at all sites. For example, some staff at Buchanisle (who embraced change) argued that they had become victims of their own success, as they now require more staff to cover on-calls. Staff shortages and lack of resources mean that a number of staff are working more hours than they should. The continued enthusiasm of staff about their new service is called into question if they have to cover on-call and find that their workloads have increased. From the perspective of midwives, change has resulted in pressurised situations, especially for lead midwives. Lead midwives described having to take on more work, of having difficulties in liaising with senior management, and with feeling responsible to the community and staff about the decisions they made. In fact, five of the units studied described how staff shortages pressurised existing staff to take on more on-call duties. Staff described how those leaving or on maternity leave were not replaced or how replacements were delayed.
Maintaining polyphonic narratives and keeping options open

The data presented above illustrates how competing change narratives not only emerge across different stakeholder groups at the same sites, but also within stakeholder groups at different sites. The story relayed by the midwives at Buchanisle contrasts with some of the concerns expressed by midwives at other sites. In presenting a positive account of a midwifery-led service it not only reports experience of change, it also serves to sustain the direction and shape of ongoing change at the local level. A dialogue with the financial and economic narrative of sustainability is always evident and yet, the maintenance of alternative stories enables redesign options to remain open. It is important to maintain these divergent narratives and not to seek closure through identifying a mono-solution to this complex issue of how best to maintain remote maternity services. Brown (2003) provides a fascinating example of how a story can be written to silence other voices and views in bringing some form of closure on what are areas of major public concern. He used the example of the formal inquiry report and the case of the Piper Alpha oil platform disaster in Scotland. For Brown, the Piper Alpha inquiry report serves to legitimate social institutions and depoliticize disaster events in using various forms of ‘verisimilitude’ to present the story (hegemonic influence over our reading and interpretation of events) of how we should make sense of what has happened. Brown argues that storytelling is an essential feature of our existence and that whilst numerous narratives co-exist (fragmented, multivocal, et cetera); the inquiry report is interesting as it attempts to present a univocal and coherent view. In this way it aims to extend hegemonic influence in seeking ‘active consent’ that things did happen the way reported. In many ways, health policy also seeks to present a rational and coherent strategy for future developments and as authors of case studies, we may also seek to present our own ‘scholastic’ and ‘objective’ account of the way things happened. However, Hazen (1993: 22) advocates that in order to enrich understanding of organization processes, the reporting of polyphony, capturing multiple simultaneous dialogues, expressing ‘harmony, dissonance, clash, counterpoint, silence’, in addition to the narratives of the loud, articulate, and powerful, must all be made available. In our case example, it is the existence and maintenance of these different stories that offers options for change and highlights the problem of trying to identify single comprehensive solutions to complex contextual-based issues. However, promoting alternative stories and ensuring that they are listened to and understood by those in more powerful positions is not an easy task, but as we shall illustrate, public issues, such as providing services in remote areas, can offer useful material for the media who are perhaps better placed to influence the view of senior managers and politicians. In the section that follows, we link media accounts with a broader analysis of stakeholder stories in examining narratives for the development of sustainable maternity services in remote Scotland.
Narratives of changing maternity services and the role of the media

A key question around the development of maternity services in remote Scotland is how ‘best’ to change to meet local ‘needs’ in different contextual settings that would also gain the ‘support’ of different stakeholders and ‘adequate resourcing’ from the NHS. From the many different ‘voices’ that expressed their views and evaluations, there is always a tendency to move towards the more dominant narratives that emerge and take precedence over the competing models or accounts of the less powerful. Within these more dominant change narratives, we often find that the detail of change processes is simplified, a clarification of alternatives often rests on two or three potential scenarios and that there is often a justification for why a particular route to change is more feasible and economically practical than others. For example, a mixture of statistical financial measures (often not specified but alluded to) with efficiency arguments may be linked with broader policy issues in promoting a compelling story of why particular changes need to be implemented in particular circumstances. For example, in a local paper, the Chief Executive of Stuartisle health board outlined the problems of recruiting medical staff to her unit and outlined a series of alternative back-up plans. When Stuartisle could not recruit under their first plan, they had a longstanding rationale for moving to another model that did not involve specialist medical staff. The way change was ‘spun’ in NHS Board press releases was also important. While the NHS Board responsible for Fraserland were reported as stating that change was needed because current services were unsafe and unsustainable, the Fergusisle health authority described their redesigned model of service as ‘an innovative plan that will buck the national trend of closing rural services’ in their local newspaper. Each story provides a justification and legitimation of change (see, Brown 2006 and 2003), either in the form of a celebration of success (bucking national trends of closure) or in playing to public fears and anxieties (unsafe so no recourse but to ‘downgrade’).

Interestingly, although four units were actively involved in service redesign (in addition to participation in this project) only change at Fraserland made a large impact in the media. Possible reasons for this were that: Fraserland was the only unit considering radically changing its staffing from three specialist medical staff to none; the timing of redesign at Fraserland coincided with the peak of a wave of Scottish protest against hospital cuts; senior staff at Highland NHS Board made some gaffes in comments on the situation which served only to aggravate local anger; MSPs of all political hues were reported in the press commenting on the Fraserland redesign – for some politicians it became a political imperative to oppose redesign. As such, opposition to the change process at Fraserland was portrayed in both local and national media. Local media set up an oppositional dynamic between, on the one hand, NHS senior managers and the Scottish Executive; and on the other, local people, a lobby group set up to oppose change, the local council, local MSPs and the church. A ‘conspiracy’ situation was often implied and sometimes overtly suggested in reporting on the comments of those who opposed change. For example, it was reported that the NHS Board had already made up their minds...
about service redesign even though they were consulting the public. Suggestions that change was about cost cutting were frequently reported. Ill-considered remarks made by NHS Board executives were reported, as were allegations of closed decision-making by sacked staff. In this story, NHS executives were demonised and change was viewed as an ill-considered cost-cutting exercise being implemented behind closed doors.

In contrast, newspapers portrayed local people as heroic, with ‘mums’ stories of traumatic births and resignations of local councillors ‘for the cause’ being reported. Overall, the situation portrayed could be described as contrasting ‘what the people want’ against ‘what the managers want’, with local people wanting access to services, a sustainable community and raising an ethical debate about equivalence of service provision across Scotland. It was implied that, although managers ostensibly said they were concerned about safety, their real motivations were cost cutting and an easily operated model of service. As with all good stories, the media aimed to write for their audience in covering the heroes, victims and villains of change – to engage the public in a controversy. These stories both sought to capture key change issues and create controversies (compelling stories) that shape the very process they are reporting on.

**Sustainability: the social and economic drivers of change**

A number of recurring drivers emerge from our analysis of the stories of key stakeholders experiencing change and these include: first, the availability and distribution of resources. Finance stood out as a key resource under short supply with increasing pressure to cut costs and rationalise operations. In addition, the problem of recruiting good staff, of retaining experienced staff and of providing appropriate training became a recurring theme. Third, the type of service provision and support services necessary to run a sustainable operation service on the islands and remote mainland of Scotland was a key topic of debate. This raised consequent issues around safety, ambulance provision and access to helicopter services, availability of specialist expertise, and concerns over the need to comply with broader European directives. Fourth, options for a new model of maternity provision and the job responsibilities and roles of staff that would operate such a service. For example, the advantages and disadvantages of consultant-led and midwifery-led care and the implications of change for the jobs of midwives. Finally, broader community issues about ensuring that younger people stay or are attracted to these remote regions and do not decide to move elsewhere because the health service provision they are going to require in starting a family is not available locally. These wider concerns around sustaining social-economic activity in remote Scotland questions efficiency drivers based on key performance measures and comparability studies on costs of running health units regardless of location. In these situations, issues of funding (that are themselves political) get linked with larger political concerns around sustainability and regional development in remote areas.
All these themes and issues arise in various forms in the competing stories that emerge and are refined and rewritten over time by different individuals and stakeholder groups. In other words, the material from these emerging concerns and perspectives can be used to script a number of different stories combining elements to suit a particular position and to influence a particular audience. For example, is our tale one of affordability and feasibility in which we raise questions about problems of recruitment and the high cost of service provision?

If greater funding (comparative to urban units) is required to sustain remote maternity services, our account highlights financial and resource problems based around an economic model of change – the logical outcome being to rationalise and reduce services with a greater focus on central hubs of expertise. However, if we promote a story about the social and political need to provide the necessary support to sustain remote communities and their development in Scotland – we move the issue from one simply about key performance indicators and costs (an economic model) - towards broader social concerns in which the politics of decision-making in terms of the NHS, the Scottish Executive and the positioning of certain MSPs - linked with the role of the media and local communities - can all significantly influence outcomes. In practice, there are a number of different stories that emerge over time that seek to make sense of change drivers, these stories are variously redefined, replaced, rejected, compete with each other and are promoted by stakeholders with the intention of moving change in certain preferred directions. Change in short, is continuously composed from a bundle of shifting narratives in which the power of stories to persuade people and shape processes should not be underestimated.

**Conclusion: the power of stories to influence behaviour and experience**

The power of a narrative to persuade is based on the extent to which it engages the audience, captures the imagination, and provides entertainment as well as the power of a compelling story to communicate ideas. Authors establish that engagement through choice of genre, writing style, presentation technique, and framing meanings to influence reader interpretations. However well crafted the narrative, however robust and compelling the theoretical statement, audiences may respond with combinations of support, reinterpretation, misinterpretation, modification, criticism, and rejection (Latour 1990: 91). In this sense, readers are not passive but perceptive and informed interpreters and active co-creators of meaning (Latour and Woolgar 1986). Audiences also act as ‘multi-conductors’ (Latour 2003) and thus, if it is in their interest to support a narrative, they may align with the account, enhancing its status. While the subversion of meaning by readers may never be fully tamed, it is clearly in the author’s interest to select a genre commensurate with audience expectations and preferences. Recalling Gabriel’s (1998) observation that the point is more important than the accuracy of the story, readers of change intervention narratives may be advised to identify the position from
which the author speaks, the genre in which the account is articulated, and the theoretical and practical implications coloured by those choices. However, readers are not fully informed, as in the selective retelling, it is never clear what information, what perspectives, what accounts the author has decided to de-emphasize, or to omit. In addition to genre-awareness, therefore, and being alert to the persuasive properties of a compelling story, audiences should be advised to approach change narratives with a sceptical and inquisitive eye for the sidelined, the silenced, the concealed, the ignored, and the excluded, that is for the material, issues, and voices that sit outside the frame of the story presented.

Change is ongoing and this is reflected in the dynamics of narrative in which stories continuously compete, evolve and are re-written. How, then, are stories and arguments discursively constructed and promoted in this contested environment? How do stories and arguments come to be discredited, discarded, resurrected? How are narratives or stories assessed, and on what criteria? Whose assessments ‘count’? How do narratives interlock discursively to produce the cognitions, decisions, and actions shaping the nature, direction, and outcomes of change?

From a respondent perspective, accounts are often based on fragmented engagement with the change process, and can be unstable and contradictory. The content of these accounts can influence and contribute to personal sense-making, self-justification, impression management, and the political agendas of individuals and groups. From a management perspective, the dominant narrative can be designed with several related outcomes in mind; individual self promotion, collective managerial credibility, building support for political agendas, influencing public perceptions and evaluations of change programmes, maintaining corporate image, developing reputation, legitimating previous decisions, providing justification for future actions, discrediting opposing views, and simply making things happen. From a research perspective, change interventions, respondent accounts, and dominant narratives generate research data, leading to a selective retelling of the event sequence for particular audiences, authored in a chosen genre or combination of genres. This selective retelling leads to a number of outcomes; the development of genre-dependent process theories of change, contributions to management practice, researcher credibility, sustained access to the research site, and the possibility to publish findings and enhance scholarly reputation.

Our essential argument is therefore that: *compelling stories not only explain what happened in the past, they are able to shape our understanding of the present and influence how we act in the future.* Respondent narratives provide the evidence base from which research narratives, causal inferences, and theories are generated. By explaining what happened, and anticipating what should happen next, accounts are post-hoc theories, and before-the-event determinants, with the potential to be causal factors in the ongoing change process (Barry and Elmes 1997; Fincham 2002). Gioia and Chitipeddi (1991) and Gioia and Thomas (1996) analyse the senior leadership role in terms of prospective sense-
making, replacing existing interpretive schemes to facilitate change by projecting aspirational images of the organization’s future. This sense-making perspective is echoed by Isabella (1990) who observes how frames of reference evolve with change, by Humphreys and Brown (2002), who analyse shared narratives as interpretive sense-making frames identifying with or resisting the management narrative, and by Fincham (2002) who notes that narratives are ‘persuasive rhetorics’ which legitimize courses of action and mobilize support. In our analysis of change interventions in remodelling maternity services in remote Scotland, we illustrate how competing and inconsistent accounts serve to maintain options and prevent closure towards a prescribed dominant model that services all sites. This finding also questions the universal validity of techniques, such as, triangulation, that attempt to handle inconsistent and unstable data. For example, should the researcher use techniques, such as triangulation, in search of the account of change or should they use analytical techniques in a way that accommodates multiple versions of events? Many company stories are definitive in describing, for example, the IBM or HP way (see, Liker 2004) and even the more critical research narratives tend to present an account of change (Winch 1983; Clark 1993). However, Boje (2001: 2) is critical of this ‘counterfeit coherence’ and Holgate (2005: 466) calls for the need to listen to the voices that are often silenced. Bedeian (1997) argues that the conventional journal article is inherently fraudulent, a ritualized fiction designed to confer credibility, legitimacy and authority to the author, by concealing and misrepresenting the processes that led to findings being presented in that manner. As change is proposed, communicated, interpreted, debated, implemented, and assessed primarily through a diversity of competing narrative accounts, attempts to triangulate a singular version of events provides at best a partial and partisan perspective, forcing the researcher to align with the sense-making, impression management, and political agendas of particular respondents. Although comparing and contrasting data from different sources and attempting to cross-validate findings from the use of multi-methods is appropriate, we contend that it is not always appropriate to use triangulation in the search for a singular account of change. Presenting the authentic story of change in our example would be a bankrupt perspective, deflecting attention from data to an understanding of outcomes that can be used to prescribe a single dominant model for maternity care. In contrast, we argue that contradictory evidence should be accommodated and not overlooked, and forward a concept of change as a multi-story process in which the power of stories to persuade is a critical component in maintaining choice and deflecting the imposition of a single simple solution to what are complex context-based issues that change over time.

References


