These stages can be compared with those described by Lewin as unfreezing, change and refreezing. The stages are anticipation, confirmation, culmination and aftermath. This is quite a useful model and can be used to explain and understand changes in a maternity hospital.

Anticipation

This is the stage at which rumours abound; some midwives have read the journals, some midwives on courses have heard about 'Changing Childbirth', there is talk of a new manager or a change agent. Each midwife constructs her version of reality; she telephones other midwives, and together they try to connect pieces of the puzzle. Some eagerly anticipate the change, some begin to make other plans.

Confirmation

Anticipation is confirmed, but there is little objective reality. There is information and misinformation, and frames of reference are based on previous experience. Each midwife has her own idea of how things may develop.

Culmination

At this stage, individuals amend their prior interpretation of forthcoming events. With more information, individuals look for clues from which to derive new meanings. Some midwives will read more, attend meetings, ask more questions.

Aftermath

This is the final stage during which the events or the new team, or the new rotas, or the new case loads are tested and tried. Reality is confirmed, and the winners and losers easily identified. Isabella argued that this is when the effects of change of the whole are interpreted by individuals and the question is asked, 'So what does this mean for me?' Individual midwives will make predictions and decide whether or not to see the change through or look for alternatives inside or outside the organisation. Change, Isabella argues, is not just a sequence but a process fuelled by a variety of interpretations, each of which provides a spur to action, creates the vision and sustains the energies of those caught up in the change (Wilson 1992, p 83).

Lancaster and Lancaster (1982) offer an interesting model to assist in understanding individual and group responses to change. The change may be seen by some as a challenge and by others as a threat. Table12.1 sets out Rogers' thinking and describes how different individuals or groups within groups may be divided.

Table 12.1 *Responses to change*

Category	*Percentage*
The innovators: enthusiastic and venturesome	2
The early adopters: respectful and obedient	13
The early majority: deliberate and thoughtful	34
The late majority: sceptical and suspicious	35
The laggards: traditional and reluctant to change	16
The saboteurs: dangerous, devious and hidden	Unknown??

(modified from Rogers 1962 and Lancaster and Lancaster 1982)

Rogers argues that, in any group, 2 per cent will be leaders or innovators of change. This small group, or even one individual, will lead the change. Innovators are usually very enthusiastic, energetic and keen to make change happen as soon as possible. They are often, but not always, the formal leaders. They see the vision, have a clear view of how things should be and rarely lose sight of that vision. They can be sent away to gather more information but will always return to continue their mission. They are persuasive, determined and active.

The group Rogers refers to as 'early adopters' make up 13% of the total. They are usually quick to come on board and become the friends and disciples of the innovators. The 'innovators' and 'early adopters', joined by the 'early majority', provide a powerful force for change. The 'late majority', around 35 per cent, remain sceptical and need much more information before they will move with the early majority. They listen to all sides but take note of what the remaining 16 per cent (the laggards) are saying. The 'laggards' hold back and are very resistant to change.

What Rogers' model does not include is a very active group well known in midwifery circles called 'the saboteurs'. This group, which can be great in number, are very difficult to discover and manage. Frequently, they are secretive about their views and appear to be contained within the late majority. Sometimes they appear to be part of the early majority and find their way on to task groups and planning teams. Their mission is to undermine, sabotage and prevent the team moving forward. They often present logical, well-prepared arguments and can seem plausible, but their mission is simply to prevent change from happening. Unfortunately, the empirical evidence suggests that they secretly undermine the activities of those committed to change and, by stealth, deception and the spreading of half truths and untruths, are able to sabotage the best of schemes.

This is a useful model that helps those involved in planning change to be aware of the dynamics of many groups. Saboteurs are not always present, but if the progress towards change is especially slow, it may be worth considering whether there is a saboteur on the team. Phillips (1983) has

also produced a simple model, based on Lewin's work, which is helpful in seeing the process of change as a series of discrete changes over time. The model assumes that 'top management' has diagnosed the need for change. (Using a familiar analogy, this 'top down' initiative can be described as the 'shower approach' as opposed to the 'bidet' or 'bottom up' approach, in which the initiative and drive come from those closely involved in the change.)

Figure 12.1, based on Phillips (1983), describes the phases in the organisation of change.

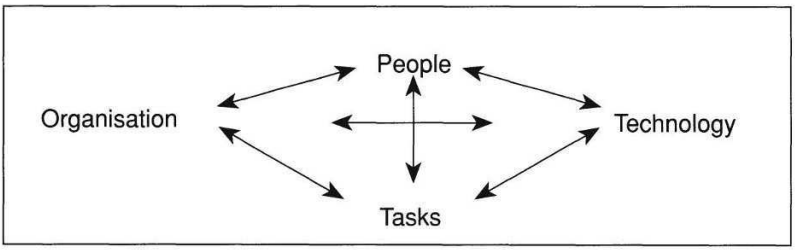
Figure 12.1 *Stages in the organisation of change*

Acceleration of momentum →

STAGE 1 Creating a sense of concern	STAGE 2 Developing a specific commitment to change	STAGE 3 Pushing for major change	STAGE 4 Reinforcing and consolidating the new vision
First serious concern	First effort to change	Real commitment to action	Evidence of turn around
		First results	Full results of change

Phillip's model depends on key individuals in the organisation being active in stage 3. The managers or leaders must motivate all others to bring about the change. Phillips argues that managers must pull, in unison and in the same direction, the same 'change levers'. The change levers are traditionally described in 'Leavitt's Diamond' (1964) (Figure 12.2).

Figure 12.2 *Leavitt's Diamond (adapted from Leavitt 1964)*



According to Kirkbridge (1993), managers can intervene in the four key areas of 'people', 'the organisation', 'technology' and 'tasks' to bring about change.

In midwifery, one of the key areas in which managers might need to intervene is 'people'; perhaps a midwife has only worked in the antenatal clinic since qualifying and needs more delivery suite experience; here staff can be prepared for their new roles through continuing education and by the support of a supervisor of midwives. The manager may need to act by increasing staff in community areas and reducing staff on underused antenatal wards. In Leavitt's Diamond, it is important to note that each of the four areas is connected and pressure on one lever produces corresponding pressure in other areas. For example, the introduction of a new information system in a maternity unit will affect people, the tasks they do and the organisation itself. In Phillips' model, the final stage of 'reinforcing and consolidating the new vision' aims at creating the capacity for further change and a willingness to adapt to subsequent change more quickly.

Most of the models described assume the existence of a process. Plant (1987) has proposed a need, commitment and shared vision model aimed at helping managers to steer the organisation through change and the consequential trauma to the workforce. However, many managers and academics are beginning to reject these and other simplistic models and see them as of use only in explaining what is happening rather than in how to help to make it happen. Most of the literature focuses on theories of change rather than on theories of changing. As such, it tends to be suitable for observers of change rather than practitioners of change. The process of change is complex and exceedingly difficult to achieve. The nature of the human animal is to cling to that which is familiar, and, for reasons as basic as ensuring survival, attempts are made to resist change. The new buzz word in understanding change is 'culture'. The key to bringing about change, according to Ouchi (1981), Deal and Kennedy (1982), Peters and Waterman (1982), Atkinson (1990), Brown (1992) and many others, is to analyse, understand and then try to change the culture. This will be discussed in the next section.

MANAGING CHANGE

Analysing and understanding resistance to change

Managing change is mainly about understanding and dealing with resistance. The most common response to a change proposal is a series of angry objections, some carefully considered logical objections and some ill-considered, illogical objections often unrelated to the proposed change.

According to Basil and Cook (1974) the origins of change can be analysed and diagnosed in three major classifications: structural–institutional, technological and social–behavioural. They argue that change is impacting on all facets of society, creating new dimensions and great uncertainty, and that the key issue facing managers today is how to manage change. In practice, this means that managers are dealing with new government and European regulations and directives, new services and demands, technological developments and a rapidly changing workforce. Individuals and organisations have to develop strategies and structures to manage change effectively, but at the root of many difficulties lies the ability of individuals and organisations to resist change. Kotter and Schlesinger (1988) say that managers need to be aware of the four most common reasons for people resisting change. These are a desire not to lose something of value, a misunderstanding of the change and its implications, a belief that the change does not make sense for the organisation and a low tolerance for change.

Harvey-Jones (1989, p 147) says of change:

> the processes (of change) are almost certainly disruptive and require adaptation to an astounding degree, adaptation which ultimately can be made on an individual and personal level

while Nadler and Tushman (1989, p 198) state:

> one of the greatest strengths of organisations is that they contain tremendous forces for stability. They are able to withstand threats and challenges to the established order. The flip side of this characteristic is that organisations (and particularly successful ones) can be inherently resistant to change, particularly change that undermines strongly held values and beliefs.

For many midwives facing the challenge of the changes set out in 'Changing Childbirth', their well-established, cherished beliefs about how midwifery care ought to be given are being challenged. They argue at conferences and study days that there was little wrong with the old familiar ways and that few women ever complained. Their fundamental beliefs and values are being challenged, and a great deal of energy is being put into resistance. Many believe that something of value may be lost (for example, continuity of carer for women whose pregnancies are considered high risk), some misunderstand the change and feel it is a cost-cutting exercise, some believe that midwifery does not need reorganising and is fine as it is, and many feel that their capacity for change is now exhausted as a result of the health service reorganisation.

In psychological terms, the pain and uncertainty of resistance can create dissonance. This is the force or energy that can motivate an indi-

vidual to take action to alleviate the discomfort caused, in this case, by the mismatch between the way things are and the way the maternity services are going to be. Resistance is the force exerted to prevent change; it can be individual and/or organisational, it can be active or passive and as a force it has to be understood and managed.

Leigh (1988) defines resistance as 'any conduct that tries to maintain the status quo in the face of pressure to change it'. It is accepted that the human animal prefers the familiar and is more comfortable with the aspects of his or her life that have been learnt through habit. Individuals faced with change, especially on the scale proposed in the maternity services, experience a range of emotions, the most common of which is fear. Harvey-Jones (1989) says that fear is an intensely personal matter and that no two individuals' fears are the same; as such, fear cannot be dealt with in generalised terms. Fear and uncertainty create mistrust and more fear. There may be role confusion and apprehension, threats to self-esteem, and anxiety about income and the ability to cope with new demands, with responses ranging from active, open, hostile, aggressive behaviour to passive resistance, characterised by regressive behaviour, non-learning and protests. Active resistance may take many forms, including slowing down, personal withdrawal (taking extended sick leave), committing minor errors, working to rule or to the letter of the UKCC Rules, or even deliberate sabotage. Those who resist may simply be afraid.

Not all change is resisted – where there are suitable rewards change may be welcomed – but resistance is bound to be a feature when midwives see themselves being asked to take on greater responsibility and work longer hours on more flexible rotas, for the same or less financial reward. Salary increases and improved status are likely to be accepted and to be used more frequently to motivate reluctant midwives. There is little evidence that improved status and greater autonomy are sufficient in themselves to overcome resistance to change.

According to Leigh (1988) and others, change can be resisted for many reasons, including: fear of loss; insecurity and fear of promotion; a memory of a previous badly handled change; a misunderstanding of change and its implications; insufficient information and no perceived benefits; a belief that changes are wrong for the organisation; uncertainty in relation to freedom and constraints; inexperience in implementing change; existing psychological and social commitments to current products or services, processes and organisations; complacency; powerful trade union attitudes to change; the complexity and fear of uncertainty; and a belief that if management want it, it must be wrong!

Finally, it is important to acknowledge that there may be legitimate resistance to change. It is very important to listen carefully to those who object to change. It is easy to label individuals as laggards or hostile resisters when it is more important to listen to their concerns, however

trivial they may first appear. It is reasonable for those planning change to anticipate opposition, but it is unreasonable to assume that all opposition is irrational.

Overcoming resistance

Harvey-Jones (1989), perhaps optimistically, states that it is better by far to achieve some change that may self-accelerate than to expend all the available energy on resistance. He advocated careful planning and selection of appropriate strategies. He anticipated that although he could change his Board (at ICI) in the first year, it would take some 4 or 5 years to begin to change attitudes and people. Perhaps, like Machiavelli (1513) and many midwifery managers in the 1990s, he has considered that:

> There is nothing more difficult to carry out nor more doubtful of success nor more dangerous to handle, than to initiate a new order of things.

Most writers agree that there are no quick-fix answers to overcoming resistance, although, as Johnson and Scholes (1989) argue, it is unrealistic to suppose that change can be implemented if current beliefs and assumptions remain the same. Overcoming resistance to change involves understanding organisations and how change takes place as well as understanding how individuals in that organisation think, believe and act.

Change and culture

Lorsch (1986) recommends a culture audit as a method of increasing understanding of the organisation and its values. The audit would help to define beliefs about goals, about distinctive competencies and the product or service on offer, and about the relationship between managers and employees. For many midwives, the chance to attempt to define their own philosophy of midwifery, as suggested by Bryar (1995), would be an important first stage in defining the culture of their organisation. The challenge to managers would be to respect and value the existing culture while encouraging flexibility and free thinking. Change has to be planned after careful analysis of the particular environment; while some general principles can be established, it is unlikely that a standard format will suit every maternity unit.

It appears that resistance can be overcome, at least in part, by careful diagnosis and understanding of the culture. This analysis, together with specific training and education programmes, is an important part of the preliminary work of change. Sometimes individuals, structures and systems and aspects of the interpersonal culture all have to be changed prior to the planned change (Goodstein & Burke 1992).

Schein (1986) believes that, in managing any change, the employee has to become motivated to unlearn something and then replace it with new learning. It is suggested that this is best achieved by identifying with a new role model or by finding information most relevant to the problem. The change, according to Schein, is then thought of as cognitive restructuring or redefinition, resulting in new perceptions, new feelings, new judgements and ultimately new behaviours. At this stage, dissonance is no longer a feature and resistance has subsided. Schein describes the role of the manager as a 'change agent' who may act and intervene at any of Lewin's stages. Schein also emphasises that unfreezing is a lengthy process and change frequently fails because this phase is too short or too ill considered.

Unlearning and relearning both require a culture change and need cultural leadership to make it happen. Leaders help to define culture and to create an environment in which change and innovation are the norm. Kanter (1983) found that segmentalist, low-innovating companies share 10 qualities (Figure 12.3). These qualities stifle innovation and are a common feature of the intensely hierarchical NHS, which has traditionally placed more emphasis on seniority than ability. In changing the organisation and philosophy of midwifery care, some of the traditional ways of the NHS, which are deeply entrenched in the culture, will need to be unlearnt.

All organisations, departments and even wards have a culture. It may not be the one that they want nor the one best suited to taking on a major change. Kanter (1983) believes that the skill of leaders lies in their ability to see the new way and then translate that vision into more concrete terms. She also believes that success breeds success, and where there is a culture of pride based on achievement, people's confidence in themselves and others increases. They become braver, achieve more and work better in teams. One of the tasks ahead is that of creating a culture in maternity units in which new ideas are welcomed, and midwives are trusted, supported and frequently praised. Midwives should be able to give care in units and homes where mistakes that are not dangerous or life-threatening are tolerated and used constructively as part of peer review and reflective learning; midwives need to be able to work where they feel empowered to take decisions about care without fear of personal criticism and attack. There are longstanding traditions and attitudes in nursing and midwifery that are, as part of the culture, passed from one generation to the next and as such are very difficult to change. Sometimes, when change seems impossible, outside consultants can be brought in to analyse and diagnose the difficulties. They study the culture and, as outsiders, are often able to see clearly what is hidden from those who are familiar with the setting. They produce a report that sets out those aspects which are preventing change and preventing improvements in care for women and their families. The words of an external consultant, written in a glossy

brochure, for which vast sums of money have often been paid, are frequently the catalyst for change. New appointments from outside the NHS Trust or area have a similar function. It seems that when an outsider tells an organisation those things that they often already know, the 'unfreezing' and changing can begin.

Figure 12.3 *Rules for stifling innovation (taken from RM Kanter,* The Change Masters: Corporate Entrepreneurs at Work, *1983. London, Routledge, p. 101. Reproduced by permission.)*

Rules for stifling innovation

1. Regard any new idea from below with suspicion – because it's new and it's from below.
2. Insist that people who need your approval to act go through several other levels of management to get their signatures.
3. Ask departments or individuals to challenge and criticise each other's proposals. (That saves you the job of deciding, you just pick the survivors.)
4. Express your criticisms freely, and withhold praise. This keeps people on their toes. Let people know that they can be fired at any time.
5. Treat identification of problems as signs of failure, to discourage people from letting you know when something in their area is not working.
6. Control everything carefully. Make sure people count everything that can be counted very carefully, frequently.
7. Make decisions to reorganise or change policies in secret and spring them on people unexpectedly. That also keeps them on their toes.
8. Make sure that requests for information are fully justified, and make sure that it is not given out to managers freely. (You don't want data in the wrong hands.)
9. Assign to lower levels of management, in the name of delegation and participation, responsibility for figuring out how to cut back, lay off, move people around or otherwise implement threatening decisions you have made. And get them to do it quickly.
10. Above all else, never forget that you, the higher ups, already know everything that is important about this business.

Force field analysis

Management texts are awash with frameworks, recipes, checklists and training games designed to help managers to analyse change, predict the consequences of failure, handle resistance and move from the actual to the optimal. All are useful in promoting thought and preventing the overenthusiastic innovator from rushing into failure.

Lewin (1951), whose model of unfreezing, changing and refreezing has been discussed above, argued that organisations exist in a state of equilibrium or *status quo* that is not conducive to change. This state of equilibrium is a result of opposing forces acting on the organisation and on individuals. He described these forces as driving and restraining forces producing a 'quasi stationary equilibrium'. The opposing pressures of driving and restraining forces produce a temporary state of balance. In order to promote the right conditions for change, to understand what is happening and to understand the forces of resistance to change, Lewin recommended the technique of force field analysis. The restraining forces should be identified with a view to removal, and then the driving forces would push forward to again achieve the quasi stationary equilibrium previously described. Refreezing would happen in the final stage. Again, even if the theory does not produce the change, analysing the forces aids understanding and subsequent communication. Figure 12.4 shows an example of a force field analysis in midwifery; it can be helpfully used as part of the diagnosis phase.

A simple chart that lists the driving and restraining forces of a particular change can help midwives see the problem more clearly and can help to focus their energies in the right direction. Too often teams become so trapped in the intricacies of off-duty rotas and on-call lists that they lose sight of the original aim. Sometimes it can be just one individual whose particular views or idiosyncrasies are preventing change. This analysis can help in the diagnosis and analysis of resistance.

Soft system methodology

The task ahead is neither easy nor straightforward. It must be planned, carefully considered and evaluated. Soft systems methodology is one of the most useful methods of evaluating organisational change. According to Checkland (1991), the approach allows the organisation to redefine systems as the programme develops. In the light of the complexities associated with implementing 'Changing Childbirth' the evaluation and review of the proposed system of care is essential. Soft systems methodology requires a conceptual model of the whole system involved in the change. Sometimes the drawing of a 'rich picture' to describe aspects of the change and see where the change is can be really helpful, especially if

Figure 12.4 *Force field analysis*

ACTUAL:	Fragmented maternity services
OPTIMAL:	Continuity of carer for all women during the childbirth experience
PROBLEM:	Traditional ways of organising care are still the norm
GOAL:	For women to have improved satisfaction with the childbirth experience

Driving forces for change →	*Restraining forces* ←
Consumer demand, pressure groups, etc.	There is nothing wrong with the present system
The market economy and a growing awareness of customer rights	Mortality and morbidity rates are improving
Formal and informal leaders, e.g. writers, lay organisations	Thought by some midwives to represent a minority
Social policy, e.g. 'Changing Childbirth', the John Major 'Charters'	Thought to express the wishes of the middle class minority
Financial. NHS Trusts are self-managing and are obliged to manage their resources effectively and efficiently	Fear of more work, more responsibility for less pay. Deteriorating working conditions and employment rights
Midwives keen to develop their skills	Some are not
Midwives want to raise their professional status and achieve greater autonomy	Some want to opt for a quiet life
Integrated services are more effective in meeting women's needs	Clinical directorates sometimes favour separate departments as being more manageable
Doctors trust midwives with normal birth	Some don't
There is duplication of effort and resources, especially in the community and in GP practices	GPs may lose out financially if they are not involved in maternity care
UK Government statements on the Health of the Nation	Things are OK as they are
World Health Organization goals of 'Health for All'	Does not apply to this area
Birth is not an illness	Labour is only normal in retrospect
Women want a positive experience of childbirth	Women want a normal healthy baby

individual midwives are allowed to contribute their version of events to the picture. The definition of the system tends to change as the work proceeds, and as more and more members of the organisation become involved in the process, the less the resistance that can be expected. Checkland believes that constant review is essential in any change process and believes that failure is more often associated with inadequate diagnosis and review than major strategic errors. He believes that it is crucial not to dismiss apparently trivial concerns but to listen carefully to the detail of concerns.

More about leaders and visions

Burns (1978), writing in support of leaders and change agents in effective change, suggests that organisational change is best led by transformational leaders as opposed to transactional leaders. The transformational leader tends to adopt a strategic vision, leads by sharing the vision and has a longer-term focus. Peters and Waterman (1982) describe the role of the chief executives in successful companies as transformational leaders. They are able to create a culture of participation, energy, change and closeness to the 'customer' through a 'hands on' involvement in the management of the organisation.

The change management 'guru' Kanter (1983), mentioned above, argues that although vision is generally thought to be the task of leaders, people at all organisational levels have a role in bringing about the change that she describes as being part of 'post entrepreneurial life'. She suggests that success is created by a three-part mix: the context set at the top, the values and goals emanating from top management by channels designed in the middle to support those values and goals, and finally project ideas bubbling up from below. She sees leadership operating at all levels rather than just at the level of top management.

Individuals resist change for a variety of reasons, the main one probably being fear. Various theories suggest ways of dealing with resistance by analysing and understanding it. However, many planned changes fail because the wrong strategy has been chosen to implement the change.

Trade unions and others

Traditionally, the role of trade unions has been to oppose and challenge management. They existed to protect the interests of the workforce rather than to support the implementation of change, but trade unions and professional organisations such as the Royal College of Midwives (RCM) do have a role to play in helping midwives to adjust to change and overcome resistance. For many years, the RCM seemed to be pulling in two directions. The professional officers were, for example, responding to the

government's agenda and giving evidence to the Health Committee set up to consider the maternity services. They argued in favour of providing women with choice, control and continuity of carer (House of Commons Health Committee 1992). They supported the proposal of improving care for women and advised that care be reorganised in order to provide greater continuity of carer. In supporting and promoting these proposals, they also believed that a reorganised maternity service would lead to an improvement in the status, position and autonomy of the midwife. However, at the same time, the industrial relations department was crying 'foul' when midwives were being asked to change their well-established working practices. The situation has improved with reorganisation (another change!), and now all officers have a professional and industrial relations role. The RCM is first and foremost a membership organisation for midwives. It continues to fight for the rights of its members, in the belief that midwives who are enjoying good working conditions and employment rights will give good care. In her 1995 end of year message, General Secretary Julia Allison said, '1995 has certainly been a year when our trade union profile has been raised significantly'. Her message addresses issues such as pay, clinical grading and professional development but says nothing about women or the need for midwives to change the ways in which they offer care. The needs of midwives, rather than the needs of childbearing women, are now the priority of the RCM.

The role of trade unions has changed significantly in the past decade, the changes in legislation introduced by the Thatcher government having significantly reduced their power and influence. In the 1990s, trade unions have a role in working with organisations and management. Their techniques now include listening, communicating, collaborating rather than confronting, facilitating, negotiating and supporting while continuing to protect the rights and interests of the workforce as they change the ways in which they work.

Selecting the right strategy

The modern language of management has changed from directing, organising and controlling towards flexibility, decentralisation, empowerment, leadership, collaboration and change. The 'new' management led by Peters and Waterman (1982), Kanter (1983, 1989), Peters and Austin (1985), Peters (1987) and others places great emphasis on appropriate interpersonal skills and on valuing individuals and their contribution to the organisation. The choice of strategy depends to a great extent on the beliefs that managers hold about the people they manage, on the speed with which the change must be brought about and on the anticipated efforts of those involved. The anticipated degree of resistance to the change is another variable to be considered.

Bennis *et al.* (1976) identify three predominant change strategies: rational–empirical, power–coercive, and normative–re-educative. Each of these strategies is based on managers' assumptions about what makes individuals and organisations willing to change or resist change.

The rational–empirical strategy is based on the belief that all human beings are reasonable and intelligent, and will select options that offer optimum benefits to themselves and the group. It assumes that knowledge is a major source of power and that, if those who have knowledge and power share this with those they manage, they will understand the reasons behind the change and thus be willing to change. Thus the change is achieved by sharing information and appealing to individuals' logical, rational understanding of the problem.

The power–coercive strategy is based on a different type of power. This strategy is based on the use or abuse of political, legal and economic sanctions to force individuals to adopt the proposed change. The assumption is that the powerless will always obey the powerful or else lose their jobs, lose money, status or privileges. It also makes assumptions about the so-called powerless. Even the powerless have considerable power to thwart the efforts of a manager if the proposals are deemed to be unrealistic, impractical and of no benefit to the employee. These two approaches can be seen as 'shower' or top-down approaches, that is, imposed from top management above.

A third approach is defined as normative–re-educative and assumes that individuals have rights and that people need to be involved in all aspects of the change process. It assumes that change is more likely to be effective and successful if it is owned by those involved. If the proposed change comes from the workforce itself (bottom-up or 'bidet'!), it is even more likely to be supported. The normative–re-educative approach needs open channels of communication and participative management styles. The identification of need for change comes from those who are most closely involved in providing the service and are therefore likely to have the most relevant solutions. It assumes that employees are committed and interested in the job and are keen to progress, develop and change.

Bennis *et al.* (1976) have defined the leadership styles that fit with each of the strategies. In power–coercive strategies, the leader must be directive, tell people what to do, order, instruct and control. In the rational–empirical strategy, the leader has to persuade, sell, enthuse, bargain and convince the employees of the need to change. In the normative–re-educative strategy, the change agent or leader has to negotiate, participate and support with information and advice. The group will be self-directing and will find the solutions to the difficulties and problems that they have identified, but change will not happen quickly.

Kotter and Schlesinger (1988) see the strategic options available to managers as existing on a continuum. At one end, the strategy calls for a

rapid implementation, a clear plan of action and little involvement of others; here resistance is merely overturned. At the other end of the continuum, the strategy calls for a slower change process, a less clear plan offering greater flexibility and greater involvement of many more people than the manager or change initiators. They argue that where speed is essential, where the initiators are very powerful, the approach is more likely to involve coercion and manipulation. Where there is a lack of information, where speed is of less importance and where the involvement of the workforce is essential, an approach that includes education and communication is more likely to be effective, albeit slower.

The changes and targets set out in 'Changing Childbirth' and other strategy documents require a major change in the philosophy and organisation of the maternity services. Such changes are likely to need a very time-consuming approach to change that involves participation, involvement, facilitation, support and negotiation. Quick-fix solutions to be implemented next week are doomed to failure.

SUMMARY

From the evidence of this chapter, it is clear that there are no easy answers. Change is painful and difficult to achieve, but midwifery has to change, and many of the rigid, dogmatic practices of the past have no place in the provision of modern health care. It is clear why childbirth has to change; it is also clear that the pressures for change come from many sources. Government policy is easy to see and blame for the disruption, but the pace of technological developments, demographic changes, social change and geographical and world events all contribute to an age of uncertainty.

Theories and models of change help midwives to analyse and understand what is happening, but, as Wilson (1992) warns, the problem in merging theory and application is that many of the assumptions, biases and contradictions of these theories are lost in the haste to apply them. The analysis stage cannot be rushed, and standard answers are not available. The key is to understand the context and thus be able to predict the opposition and the likely outcome of action taken. Other models, such as those described by Marris (1986), help managers to understand the effects of change and deal with the workforce with compassion and sensitivity. The model offered by Rogers (1962) helps in understanding how a group responds to change and helps managers to respect those who are reluctant to go along with change at the beginning. Leaders have a major role in supporting and guiding in a change process. Their skill is in keeping alive the vision of how things might be. They need to be powerful communicators with well-developed interpersonal skills. They need to be able to listen to the laggards and not dismiss their concerns. They need

energy, enthusiasm and the commitment of those who share their beliefs and philosophy.

Those whose task it is to manage change need to understand change, the processes and why change is resisted. They need to understand the culture of the organisation and the beliefs and values of those who are employed there. They also need to evaluate and review the process of change at frequent intervals. Those who initiate and manage change have to listen, involve others in the process and be prepared to modify their own cherished ideas and schemes. Many changes fail because of poor interpersonal skills or because managers have selected an inappropriate strategy for change. Strategies frequently reflect the assumptions held about the workforce. It is worth managers thinking about how they would describe the staff of their department to an alien from another planet! If the manager believes in the staff, she or he is more likely to trust them with the task of making the change happen.

There has never been a more important time for leaders in midwifery; managers and leaders, who are not necessarily the same people, need to understand the processes, complexity and nature of change in order to steer the profession through this age of uncertainty.

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