Crossing multidisciplinary divides: exploring professional hierarchies and boundaries in focus groups

Dr Emma K. Clavering and Dr Janice McLaughlin
University of Newcastle

Dr Emma Clavering is a Research Associate based in the Sociology and Social Policy Subject Area, at the University of Newcastle. For the last three years she has been working on a study, funded by the Economic and Social Research Council (ESRC), of parents with very young disabled children and relevant professionals, with Dr Janice McLaughlin and colleagues at the University of Sheffield. This follows a Ph.D. that was a study of the lives, experiences and identities of lone parents living in Newcastle. Both studies involved the use of focus groups in ethnographic research in areas of exclusion and complex ethical and research contexts. Her research interests include exploring how identities are constituted and constructed, and developing a multilayered approach to qualitative methodology.

Dr Janice McLaughlin is a Senior Lecturer in Sociology and Research Director of the Policy, Ethics and Life Sciences Institute (PEALS), at the University of Newcastle. Her research examines the varied social and ethical dimensions to professional practices within healthcare, in particular the interactions and meanings generated between professionals and service users. Current research projects include 'Parents, Professionals and Disabled Babies: Identifying Enabling Care' (with Dr Dan Goodley, Sheffield, ESRC funded) and ‘Attitudes to pregnancy risk amongst women with Type 1 diabetes’ (funded by Newcastle Healthcare Charity). She has published widely in journals and recent books include. Feminist Social and Political Theory: Contemporary Debates and Dialogues. Basingstoke: Palgrave.
Newcastle upon Tyne
NE1 7RU
Janice.mclaughlin@ncl.ac.uk
Tel: 01912227511
Fax:01912227497
Crossing multidisciplinary divides: exploring professional hierarchies and boundaries in focus groups

Abstract

Focus groups are an important element of qualitative health research, valued for the forms of knowledge and understanding that emerge from interactions amongst participants. Common advice for focus groups within health research is to limit the level of variation amongst respondents in order to generate comprehensive discussion and shared knowledge. In this article we critically examine this advice, proposing instead that it is useful to acknowledge and, at times, consciously build in heterogeneity across categories of those present. The benefit of doing this is that the interaction thus generated can be used as a space within which to explore differing professional positions and interpretations of issues under discussion. Using research we have done, we explore the practical issues involved in getting different health and social care professionals together and go on to discuss the value and significance of using focus groups to explore the production of professional hierarchies and boundaries.

Key Words: Focus Groups, Health and social care professionals.
Crossing multidisciplinary divides: exploring professional hierarchies and boundaries in focus groups

Introduction

Focus groups are research environments in which small groups of participants are encouraged by the facilitator/s to build on a range and depth of ideas being discussed with other participants present (Krueger, 1994; Morgan, 1993). Their use, and approaches to them, has changed significantly since they were first introduced in the 1920s as a tool for market research (for example, Bogardus, 1926). In the 1950s Merton was the first to use them in social research, mainly as a tool to develop interview questions (Merton, Fiske, & Kendall, 1956). Since then their use has expanded in a variety of academic, market research and political contexts and it is now more common to see them used as a research tool in their own right (Kamberelis & Dimitriadis, 2005; Morgan, 1998). They are used to provide a context within which the interaction between individuals generates data unavailable through one to one interviews (Kitzinger, 1994; Wilkinson, 1999).

Within health research focus groups have become particularly popular, both because they are time efficient, but also because they provide a useful vehicle for researchers to explore deeper aspects of health professionals’ work, and the cultural and social dynamics within healthcare settings. Within health research, and in broader social research using focus groups, the tendency is to advocate homogeneity amongst the participants (Carey, 1994; Krueger, 1994). In this article we seek to explore, based on our own use of focus groups, the benefits to interaction of deliberately seeking heterogeneity within focus group participants. As well as aiming to be a useful addition to existing guidelines for focus group research, we bring new insight into
interactions within groups through which health and social care professional cultures, hierarchies and boundaries can be examined.

As part of an ongoing three year study to understand enabling care practices for families with young infants with disabilities¹ in the United Kingdom (UK), professionals from different care sectors (health, social, education and voluntary) were invited to attend a series of three focus groups. All aspects of the research project had approval from the relevant National Health Service (NHS) local research ethics committees, three in total due to the geographical areas we were working in.

In the early exploratory fieldwork, several comments were made from both researchers and health and social care professionals, which suggested that it would be a near-impossible challenge to get representatives from across the different sectors to attend a single meeting. Researchers warned that because we were attempting to involve professionals from across the different realms of health and social care and also across hierarchical boundaries, the risk was that some present would feel uncomfortable discussing some of the issues and others would feel unable to speak freely in front of more powerful colleagues. The example often given was that nurses would feel unable to speak up in opposition to consultant specialists.

However, consciously we decided not to follow the strategy of different groups for different ‘types’. We felt that such restrictions on membership imposed certain

¹ Study title: ‘Parents, Professionals and Disabled Babies: Identifying Enabling Care Practices’, Dr Janice McLaughlin and Dr Emma Clavering (Newcastle University), and Dr Dan Goodley, Dr Pamela Fisher and Dr Claire Tregaskis (Sheffield University). Funded by the Economic and Social Research Council (RES-000-23-0129). Further details available at: www.shef.ac.uk/inclusive-education/disabledbabies
assumptions with little opportunity for challenge. Indeed the research team would have been left to imagine who might or might not speak in front of whom. We decided to press ahead with the multidisciplinary approach, by both seeking to address the practical problems and also challenging some of the assumptions about how group participants may or may not interact. We therefore decided to attempt to recruit professionals from across different areas of health and social care, across professional status and personal backgrounds, building in diversity, to begin to explore how these dynamics might play out in reality. In this article we will discuss how we practically addressed the problem of getting different kinds of professionals together and also how the operation of the focus groups made us rethink the cultural and political arguments for keeping professionals apart. First, we will discuss how the emphasis on interactionism has developed within methodological debates about focus groups and then why a focus group organized around heterogeneity makes conceptual and empirical sense in the context of studying health and social care professionals.

Group interaction

Group interactions are at the heart of methodological debates about the value of focus groups and how they should occur (Kitzinger, 1994; Puchta & Potter, 2004). Much of the practical discussion, particularly in areas of applied and policy use, concentrates on ensuring that the group is organized in such a way that barriers to interaction, such as hierarchies, cultural differences and lack of familiarity, are reduced (Robinson, 1999; Ruff, Alexander, & McKie, 2005). Carey, for example, notes how a group member’s contribution, or ‘talk time’ (1994. p. 236) can be influenced by their perceptions of other group members. As a result Carey advocates separating different categories of participant to allow people who share similar viewpoints to discuss
issues without fear of disagreement (Tiggemann, Gardiner, & Slater, 2000). Barbour echoes this view by suggesting that ‘Homogeneous groups offer participants a relatively safe environment in which to share their experiences’ (Barbour, 2005. p. 743).

From a different political standpoint, Kamerelis and Dimitriadis argue that Marxists and feminists have used focus groups as a way of bringing people with shared interests and viewpoints together in order for new consciousness of positions of oppression to emerge and new critical knowledge from which change can occur to develop: ‘the synergy and dynamism generated within homogeneous collectives often reveal unarticulated norms and normative assumptions’ (2005. p. 903). Callaghan’s (2005) research is an excellent contemporary example of such an approach, bringing women of similar class positions together to develop collective and critical knowledge of gender relations, through the articulation of shared understanding and position.

Researchers using focus groups to aid political goals of consciousness raising are approaching interactionism in a distinct way. In the political context it is not about distilling the influence of interaction in order to allow people to speak more freely, but instead to see the interaction itself as the function of the focus group. In this context homogeneity is about developing an interactive dynamic through which new understandings emerge, something only possible through group interaction. An important aspect of the analysis is to explore the group discussions and discourses as a microcosm of the wider world within which such groups belong, that is that what is being explored is how people define themselves and their world in a collective context. It points, as Kamberelis and Dimitriadis argue, to the social fact that ‘group
characteristics and dynamics’ are ‘constitutive forces in the construction of meaning and the practice of social life’ (2005. p. 902). Therefore, homogeneity takes on an added conceptual dimension, where it not only allows people to talk freely, it also ‘reveal[s] unarticulated norms and normative assumptions’ (2005. p. 903). For Allen (2005), in her research on adolescent masculinity, the interaction within the focus groups are examples in themselves of ‘identity work’ where ‘male sexuality in action’ (2005. p. 37) could be observed.

If we look at how focus groups can be used in this way when working with health and social care professionals they can be thought of as important sites where the ways in which professionals construct their claims to identity, status and power can be explored (McLaughlin & Webster, 1998). As Fournier argues the professional project ‘entails not only an occupational group appropriating a field or discipline as its exclusive area of jurisdiction and expertise but also the making of this field as a legitimate and valid area of knowledge and intervention on the world’ (1997. p. 3). Therefore, focus groups of professionals can create the interactional dynamic where ‘appropriation’ in ‘action’ is highlighted. For example, Lambert and McKevitt (2002) advocate using focus groups to go beyond representing what people say in order to look at the production and maintenance of cultural meanings and identities. By providing a context within which professionals talk about what they do and who they are, focus groups become a site where ‘narrative reconstructions (biographically specific reinterpretation of what has happened in the past), and actual practices (what really happens)’ (2002. p. 211) can be analyzed.
If the object of interaction is to explore group dynamics, then we would argue it opens up the possibility that what can be explored is not just how meanings, identities and understandings develop in homogeneous groups; but also how heterogeneous groups may influence these constructions. This opens up designing focus groups in a way that makes use of, rather than tries to eliminate, issues such as hierarchy, cultural difference and lack of familiarity (Lawton & Parker, 1999). Differences of opinion and experience can generate useful discussion and in addition, and perhaps more importantly, indicate how people define and construct their position and identity in contrast or opposition to others. Group diversity encourages people to explain their reasoning and in so doing reveals intricate thoughts that may challenge preconceptions about what each member means by their account. It also usefully acknowledges that homogeneity, as Kitzinger (1994) argues, is rarely possible, even within groups superficially similar and familiar to each other.

Much health research using focus groups for professionals continues to advocate homogeneity for the reasons discussed above, in particular concerns over the silencing impact of hierarchies amongst medical professionals (Barbour, 2005; Kitzinger, 1995; Robinson, 1999). However, shifts in professional working in healthcare and how professional groupings are conceptualized mean that homogeneity is not a necessary precursor to useful focus group interactions amongst professionals. In contemporary sociological work examining professional organizations there is a call to move beyond understanding them as a ‘culturally defined collectivity… a relatively homogeneous cultural system’ (Atkinson, 1995. p. 29). For Atkinson sociology and anthropology have themselves constructed the narrative of powerful professional groups able to maintain singular and unquestioned control over knowledge and
expertise. Instead he argues that if you explore how professionals, even within one grouping, work and talk day to day you will see different voices and discourses with contrasting constructions of knowledge and expertise. Within medicine ‘medical discourse does not articulate a single lifeworld’ (1995, p. 147). As far back as 1978 in a speech reprinted in 1988 Bucher argued that the sociology of professions had constructed doctors as the privileged group within medicine through the sole consideration of them in accounts of medicine. Behind the image of omnipotent doctors was a far more complex picture of ‘a teeming arena, with more and more groups crowding in, jockeying for position, rearranging themselves’ (Bucher, 1988, p. 131). What such accounts indicate is that professional hierarchies and claims to status are not fixed and unbending; instead they are in constant flux and negotiation as professional boundaries shift (Deverell & Sharma, 2000).

The appreciation of professional power as more fluid and negotiated has coincided with significant changes in the context within which professionals operate. Shifts in technology, government and capitalism have undermined the entrenched position of some professionals and their organizations. This has given rise to arguments about the ‘proletarianisation’ or ‘deprofessionalisation’ of such groups (Aldridge, 1996; Freidson, 1994). In the context of medicine, doctors in the UK (but echoed elsewhere in different healthcare systems) have found their status and autonomy undermined over the last two decades (Dominelli, 1996; Reed, 1996). This began with the reforms of the NHS brought in under the Thatcher government and has carried on under the current Labour government through the use of evidence based medicine and the role of policy making organizations such as the National Institute for Clinical Excellence (NICE) (McLaughlin, 2001).
Elston (1991) argues that the model of unquestioned dominance of doctors over nurses has not kept up with how both professions exist and work together. In intensive care units for babies nurses are highly trained and are often in a position to advise consultants about caring for babies struggling on the edge of life and at the boundaries of scientific knowledge. During exploratory observations at an intensive care unit we were told of nurse-led practices that have been developed and formalized into current understanding of best-practice. For example, guidelines on the most appropriate environment for babies in incubators advising ward lights to be as dim as possible first suggested and managed by nurses, now several years later written into training packages for pediatricians. To think of such nurses as unwilling or unable to speak in front of doctors is in effect insulting to the role and expertise they have obtained.

In the UK in many areas of both hospital based and community based medicine the push is away from hierarchical modes of working, towards team-working across traditional boundaries in order for both shared decision making and accountability (Atkins, 1998; Department of Health, 2000; Nolan, 1999). Bringing multidisciplinarity into reality is proving to be a difficult task, existing modes of working, institutional bureaucracy and professional organizations are seen as some of the key barriers to successful cross professional team working (Cameron & Lart, 2000; Sloper, 2004). There is now a need for research and analysis that explore how professional groupings respond to such changes and renegotiate shifting professional boundaries and claims to identity, knowledge and expertise. For example, Lingard et.al. have studied the operation of multidisciplinary groups in the Intensive Care setting and argue that a multidisciplinary team is ‘not a unified body but rather is a
complex and fluid entity composed of core and expanding groups. Memberships in these groups are continually negotiated on the basis of relative professional roles, immediate needs and tacit ‘rules of play’ (Lingard, Espin, Evans, & Hawryluck, 2004. p. R404).

In developing our focus groups from the beginning what we aimed for was the creation of a space through which different kinds of health and social care professionals could, in conversation with each other, explore the concepts of our research. Through those conservations we could then identify different professional frameworks, made visible through the differences presented between them. If we had kept professional groupings apart we would have been unable to capture the ways in which the groupings construct their differing positions on the debates being examined. However, to do this, we had to ensure we organized the focus groups in such a way that we got enough different kinds of professionals to appear.

**Getting professionals to turn up**

We prepared for the first group, and subsequent ones, well in advance (initial preparations for the first group began three months before it was held, and dates for subsequent groups were confirmed with participants at the end of each session) ensuring all professionals who had shown an interest in attending were given advance clear notification of the date, time and venue, along with reminders nearer the time and information to help prepare them for the focus of the discussion. The invitation process itself was carefully planned; rather than simply write to or cold call people, one of us met each prospective person or manager within a particular area.
The meeting began by introducing the research, before then moving on to discuss the focus group. This proved highly fruitful; by talking about the research first those we met were able to see the relevance to them. Each person we spoke to about participating in the research received an information sheet that detailed the project as a whole and the role of the focus groups within that. We stressed that one aim of the focus group was to discuss research findings from our interviews with parents (while protecting anonymity). In so doing we stressed the value of attendance for them, at a time when professionals are encouraged to find out more about what users think of their service provision. In speaking to them we also obtained valuable insight into how the teams worked, how they understood the issues and problems they faced and what tensions were already there within the multidisciplinary teams and relations. The issues identified during these individual meetings proved not only useful for the focus groups, but also for the research as a whole. A final benefit was the snowballing effect the meetings had, with one professional pointing us towards another contact in a related or different service. While this approach to inviting possible participants was time consuming, we would argue that if researchers have the time and resources it is an invaluable way of incorporating people into the research.

Each session was held at the university. This was practically advantageous for the research team, but also meant that the sessions were held on neutral territory for the participants. The sessions were timed to start at 11:00 am and conclude with lunch. At first we thought most would not stay for lunch, however, in each group the majority stayed. In discussions over lunch it was clear that the group session and the space for lunch after was an opportunity for them to network with each other. While several of the people work within related multidisciplinary teams they are not all physically
based together, so much communication occurs via email and telephone. The opportunity to meet up, away from the demands of the normal workday, allowed them the chance to catch up on different events and activities that were ongoing. Therefore, rather than the focus group being an interruption to their working lives, because they felt the group was relevant to them and because it provided them with the opportunity to meet and discuss both the issues we were addressing and other issues of concern to them, it was a valuable working and networking activity. This was emphasized at the end of the final group where one of the core members who had been able to attend all sessions, commented on the need for them to continue to meet:

The stories we have read… they are hugely challenging, they have had an emotional impact on all of us, reading the stories of people and their lives as they see them, identifying other people that we work with within their stories. As grassroots workers we are challenged by that and I would like to see us having a role taking this agenda to another tier of management. So that they would have a greater understanding of the reality of the things they are actually doing. (Focus Group [FG] 3)

Running the session

The agenda for each session was based around issues that were emerging from the interviews with parents. In each session narratives drawn from different parental accounts (a strategy that also helped protect the anonymity of parents) were used as a way of stimulating discussion. In order to get the most from the sessions and to allow the participants to know what would be discussed, parental narratives were sent with
the agenda several days before the session took place. An abbreviated example of a narrative around diagnosis is given below.

**Amy, Paul and Adrian**
Amy (mother), Paul (father), Adrian (4, diagnostic label of autism)

Adrian is eight now, my initial concerns came about when he was one, and I saw him interact with other children and compared them. I was unhappy with his development, there was just something not right, I did not know what it was, but I felt his development was just not right. He wasn’t waving or pointing; he just generally didn’t seem interested in other people. The professionals I spoke to first about Adrian’s development mostly rejected my concerns - one was even very aggressive towards me and told me that I should not be diagnosing my own child. There were a few professionals who seemed to share my concerns, but I felt they did little to take things forward. So it really was a constant battle to get people to listen. I sounded almost obsessed.

The different narratives (two per focus group) explored issues and experiences we have identified through the parents, these included, the distress triggered by the way in which diagnosis was communicated, social isolation, cultural differences, what is enabling care, what are enabling care practices, transitions in parents’ lives and in service provision and what the future holds for the care services.

At the beginning of each group we laid out guidelines for how the discussion should go. We stressed two important factors, one that our research and these sessions were not part of an evaluation of practice and two, the comments made by people were in confidence, while the findings from the research would be shared, the individuals present and their local authority would not be identified, nor any information that could potentially identify them. We discussed our roles as facilitators and that we would be very much in the background encouraging discussion and probing, but that
the floor was theirs to raise issues and take discussion forward. By having future focus groups and allowing time in-between we were able to reflect on how each group had gone before the next. In addition, at the end of each session the participants were given a feedback sheet with a range of questions to help us design subsequent sessions.

Our aim was to have no more than two representatives from specific professional groups in order to have the largest mix possible, without one voice dominating others. As much as possible we aimed for the same people to come to the three focus groups (which were held approximately seven months apart). This was to develop as much cross-dialogue between the groups as possible. In addition as we got to know the individuals and they us, we were able to press more on the assumptions they maintained within their practice and present more challenging issues to them. In focus group one (FG1) we had nine participants, five members worked in healthcare in the following roles: physiotherapist, speech and language therapist, community nurse, staff nurse in an intensive care environment and a hospital based pediatrician, also in an intensive care environment. The other four worked within social services as special education teachers and social workers. In focus group two (FG2) we had ten people present, seven of the above professionals attended, joined by a community pediatrician, a child play worker and an education psychologist. In focus group three (FG3) we had six people present, five of whom had been present at focus group two, the new member was a social worker.

In total four people were able to attend all three focus groups, four people attended twice and three people attended once. The last focus group had the least numbers
present. The drop-out rate was caused by two factors. First, the two doctors (the hospital based consultant and the community pediatrician) were on leave at the time of the third group. Second, for others work commitments meant it was not possible to attend for a third time. Only in the second focus group was one of the participants male (the child play worker).

Despite our original intention to maintain the same membership across the three focus groups, over time we did have some movement as indicated above. In reflection, this proved useful in de-stabilizing the group by bringing new voices and perspectives to the discussion. This worked particularly well at the third focus group when the new member, who worked closely with black and ethnic minority families, challenged implicit practices and assumptions relating to cultural issues in ways that had not occurred before. For example, in the interaction below two professionals stress the need to link parents to particular organizations who will help them, however the new participant challenges the benefits of doing this for the groups she works with, as their specific cultural and language requirements are rarely supported by the types of organization the first participants had praised for their value to parents:

Professional 1: But that’s why the [family link-up service] is so good because within the context of the healthcare system parents will be given information which relates to their child’s condition which is quite clinical, the information that they’re given however [the family link-up service] will put them in touch with another family who lives with a child with the same condition and so what you get from that family is ‘oh yes we came across that and we tried x, y and z and we did that and this worked’ and you know and give us a ring and let us know…
Professional 2: Cos we have contacted that help group and they send the parent up to the unit and erm and it's like, it's like light dawning for this parent, aaarrh ‘there’s somebody else out there has the same thing as our little boy, as my little boy’.

Professional 3: Can I say something, yes that’s fine but you know it depends… is it appropriate for that parent? For example I have a parent who cannot speak English you know and they are linked with a group of people where they feel not very confident as to raise whatever it is about the child… what I’m seeing is that sometimes there are so many groups er we have to, for me you know, is it appropriate for them? Because they will not attend it...

(FG3)

Bringing in her different perspective, based on the parents she works with, usefully troubled the consensus around what are the problems and issues. It also challenged the other professionals too; such issues and considerations should not be a surprise or new to any of the professionals present, for in their day-to-day service provision they are dealing with the same people the new participant worked with.

Professional boundaries

Through our analysis of the three sessions we identified relevant issues for our research. A particular area returned to at various points was diagnosis; another was the significance of cultural differences amongst service users and professionals and how such differences are dealt with (or in many cases not); in the background was always the influence of organizational constraints, particularly the finite nature of resources and the slow speed at which organizational change and response occurs.
What we will focus the discussion on here is how boundaries between different professional groups emerged within the focus group setting and how such boundaries were reflected on within discussions of how their work is increasingly sitting within a multidisciplinary and multi-agency context. The main areas of interest for the analysis presented here are ways in which hierarchies were played out in the groups and how perceived divisions between community and institution based work were articulated.

Perhaps due to the way we organized the groups and the individual approaches of those who attended, there was little evidence of traditional medical hierarchies in operation in the way in which people took different positions on issues, spoke and listened to each other. Nurses from both the hospital and community setting appeared to speak openly in front of other professionals, including doctors. If anything, in the first focus group when there was only one doctor present, it was this participant who faced the most difficult questions, often acknowledging limitations in practice and the need for other professionals to be involved in care. However, this is not to suggest that medical hierarchies are no longer part of the working lives of these professionals, or the service provision that users receive. At several occasions people spoke of the continued, but shifting presence of traditional medical hierarchies within their work:

Sometimes you feel there’s a natural hierarchy, perhaps with pediatricians at the top and then the whole thing sort of branching down at different levels and if you’re sort of a couple of layers down that level, then you sometimes feel it really hard to approach pediatricians... I think people are aware of their positions of power over each other and it’s actually quite hard to break through that... (FG1)
Within the discussion there was a consensus that it was within medicine that the hierarchies remained most entrenched. Several participants were keen to distance themselves from what they asserted came with such traditional hierarchies, in particular the assumption that those medical professionals at the top knew best and knew all. Professionals based in the community argued that they battled against the pattern of power and interaction created by the intensity of the hospital setting:

But I think parents sometimes expect… the power relationship within hospitals, where they are the person out of control, they are very beholden to the people looking after their child… until that’s shifting away we can be on a loser, with this, how we can work forward, if they’ve already got that perception, that you are the person with the power, with the control? And we are not, none of us are, none of us have all the answers, none of us always know, especially where there is not a clear diagnosis, it’s very difficult. (FG1)

Examining the interactions between the participants across the sessions it became clear that the boundary that was significant to the discussions and different positions articulated was that between community and hospital based practitioners. Community based nurses presented themselves as having more in common with the other community based practitioners than they did with the nurse based in the medical environment. There were marked differences in how professional identity, role and discursive presentation were articulated between the hospital and community based professionals. The hospital based staff appeared most embedded in the medical model of understanding disability, for example when asked in the first session what was the most challenging and rewarding aspect of the role, one of the professionals based within a hospital immediately focused on the medical aspects of keeping the baby
alive and the ‘tragedy’ of disability, which disability studies associates with the medical model of disability (Larson, 1998; Oliver, 1990):

... the other challenging thing is if they don’t make it and they die and, and it’s the parents and how we react to it, what we say to them, the rewards are enormous, huge, um, seeing the parents’ faces when they’re taking that baby downstairs and putting them in the car, and you, can actually feel um how happy they are and its um it’s really, really nice and they cry and they hug you, they are so grateful, you could be sending the baby home with cerebral palsy, and awful disabilities, but they are so grateful to you just getting them out there at the end of the day, um, that’s the reward. (FG1)

This kind of talk sits within the medical model, seeing the condition at the centre of all things, the professional’s role is to ensure parents ‘accept’ the diagnosis, go through the required stages of grief and then work with professionals to help the child. This understanding sits at a very individual level, while involving clear empathy for the child and family; it removes the situation from its social and cultural influences and constructs impairment as primarily a medical problem and the pain that parents may experience as a result of the impairment. Professionals from outside the medical arena of the hospital, while still within the health world, were keen in contrast to identify problems as not relating to impairment, but instead to the social and institutional contexts parents are suddenly placed within upon the diagnosis of their child. One community based professional faced with the same request to consider the greatest challenge in their role replied in the following way:

... things aren’t in place or they don’t happen quick enough and we’re not able to be responsive to need because there is just aren’t the services out there for
these children and their families, the right level of support, this goes right from when they first come home into education... (FG1)

Throughout the sessions, participants returned to the differences between the ways in which those based in the hospital saw disability and support in contrast to those in the community. What was echoed each time was the restriction in knowledge and understanding that emerged within the boundaries of medical practice, a boundary that restricted the ability of medical professionals (both nurses and doctors) to understand the lives and needs of parents. For example, below one of participants working in the community directly challenged one of the hospital staff for responding to a question by celebrating the use of genetics to diagnose conditions:

Some practices are very medical… I think, like you are a medical professional, so you know all these things, some parents don’t want to have in-depth knowledge of the diagnosis and everything, they want to concentrate on how they are going to be able to cope with the child. (FG3)

Following on from this, community based practitioners were keen to challenge the model of personal tragedy and grief articulated by hospital staff. In direct response to a hospital based member of staff highlighting the standard narrative of the grief parents’ experience, one community worker interjected to describe the grief process in a more complicated and socially imposed way:

…people are expected to feel a certain way, expected to be angry, expected to be cross, expected to not like it and that is extra pressure, to fit in and then it is other people’s pressure, and other people’s feelings, that makes it more difficult for them, how are they going to tell other people. They have dealt with it, if they have come to that point where they have come to terms with the
diagnosis themselves, then it is how they deal with the other family and friends, who haven’t come to terms with it, that can become the pressure, equally society as a whole who haven’t accepted it... (FG1)

Outside of the medical context and intensity of the hospital setting, community professionals have a discursive and experiential space within which they construct their role and identity within a wider social and health framework. Having this space and being seen in this way was fundamentally important to their professional identity. This was made very explicit at the first focus group when two community based health professionals arrived wearing uniforms to everyone’s surprise. In a change to Hospital Trust policy, from that morning community staff were required to wear a uniform. This clearly angered both the community professionals and others they worked with. The professionals were strongly against the policy, they felt that families would not like the change and that it threatened the relationship they had with them, which incorporated some level of familiarity and informality; it challenged their role and identity and placed them more strictly within a formal hierarchy, in comparison to others not in uniform or in less obtrusive uniforms. The uniform stressed the medical aspect to their work; they treat illness and disease rather than a more holistic and social understanding of the community role they play.

Being seen as more than medical professionals who treat a condition was an important part of the professional identity of the community based practitioners. This meant that in the focus groups those from the health arena working in the community asserted values and positions that created alliances with the other community based practitioners and boundary distinctions between themselves and the hospital based
healthcare professionals. For example, at various points community based participants argued that they could not and did not just treat the particular medical conditions a child had, instead supporting families required the need to understand their wider social context:

I don’t think we could actually work with families without an understanding of those pressures, that is part of family life, if we don’t have an understanding of that, why they don’t turn up or they are not in, if we can’t work that one out then we can’t be working with the families really, you have got to have that understanding, you have got to know what else is going on in their lives, to actually be able to work with that family. (FG1)

In response, hospital based professionals acknowledged that within the medical world of the hospital it was difficult for them to capture such contexts in their interactions with parents. They work in an environment that is removed from those contexts and people act out particular identities/performances that may disguise what is happening outside in order to be accepted in the hospital environment:

We just don’t see it, someone comes to clinic and they are well dressed, it’s all, you just don’t know what on earth is going on, why they have missed the appointment, is there actually something going on? We do miss out on a lot of things that are going on. (FG1)

Community based professionals were keen to praise the benefits of multidisciplinary working for parent centered care; in particular its role in providing support that fully understood the needs of parents. In discussion over the difficulties embedded in generating multidisciplinary working, as in other areas of debate, the community based professionals were keen to create distance between themselves and hospital based staff by defining them (or their culture) as the problem:
There has been, particularly in health, a culture of ‘we are the gatekeeper, we know, therefore’. We are now saying ‘I don’t know’, there is a shift in that, we are coming much more ready to say we don’t know the answer and we can work together to find it out, creating that, that is a cultural change over time. Historically the doctor knows best, the public perceive that they go to a doctor or a nurse or a social worker and they will solve their problem for them, that is a societal shift that is needed, not just an organizational shift. I think it is shifting, but not in all areas of society, you are told you go to the doctor and they are supposed to know, solve your problem, cure you, that’s where the challenges come in, that is where the conflict comes, people don’t have the answer and they should.’ (FG3)

According to the community workers, given that hospital staff were the most trapped within medical understandings of working and treatment, it would be within this sector that the shift to multidisciplinary working would be the most difficult:

Some groups are going to find it more difficult than others… you have your medics, not being disloyal to them, because there are some very good medics out there, you very much protect your own, you stick together in that club, it does make it very difficult. (FG3)

The turn in language to direct the comments to those hospital based staff present (‘you protect your own’) is significant in enforcing the professional boundary between the two groups. In making this point and directing it personally towards the hospital based staff present, the community based practitioners were reinforcing the professional boundaries they were constructing between their practice and that of the hospital staff, allowing them to present their professional roles and identities, in contrast, to be closer to parents and the social and cultural worlds they live within.
Reflections on the process

The success of the groups depended on several factors including careful planning and careful selection that ensured that no one professional category dominated. In addition, the follow up focus groups allowed us to build up trust and relationships with the participants. This does not mean that there were no limitations to what we were able to achieve. It seems unlikely that the professionals who attended are representative either of the groups they belonged to, or to the set of professional relationships and struggles that occur within health and social care. For all the diversity of professional backgrounds and status, what connected these professionals together was their involvement with families with young impaired children, and as emerged, their commitment (though expressed differently) to what they considered enabling care. The fact that all but one participant was female, unsurprising in the ‘caring’ professions, influenced the form of dialogue and perhaps the absence of direct conflict. Even those from high up in the formal hierarchy were not that high up; if it had been one of the male senior consultants from the intensive care unit, rather than the female pediatrician, it is possible that the input from the medical side and from others would have been different and the pattern of boundaries and hierarchies witnessed differently.

For our research, bringing a variety of professionals together in the way we did was useful. First, it allowed initial ideas being generated by our work with parents to reach professionals across sectors and statuses (including those we met during the recruitment process). Second, the groups were invaluable for our research, for example the reflections professionals made about their practice and the experiences of
those they support were fed back to parents and often usefully challenged. Third, it did indicate differences in perspective, crucially between community and hospital. Through analyzing the interactions we could see how community practitioners actively construct their identity and role through the ways in which they conceive boundaries between themselves and hospital based practitioners, even within the same formal profession. In this way, the interactions that occurred were a window into wider boundaries and tensions of multidisciplinary professional practice. Without a methodology that brought together the different categories of health and social care professionals we would not have been able to develop this substantive finding.

The findings and issues that emerge from focus groups, as with any other qualitative method, will depend on many factors, including the design of the sessions. However, the biggest factor will be the perspectives, interests and worldviews of those who participate. What those factors will be cannot be predicted by professional label or role, instead focus groups allow an opportunity to provide a space within which such differences become visible and connections made to how professionals make sense of their world and interact with others who join them there. There is now little logic to only designing focus groups to keep different health professionals apart, when professionals are working together (however problematically) day to day and when notions of homogeneity are so problematized for disguising the variations that occur within superficially similar groups. Seeking to work within singular professional groupings fails to capture the variety within such groups, fails to use the opportunity of mixing the groups to identify where the disputes and boundaries lie and fails to recognize the complexity and fluidity of the shifting professional boundaries now developing in an era of increasing multidisciplinary working, particularly in health.
and social care. Boundaries and hierarchies still exist, including some of the established ones, however, focus group design should not pre-empt where those boundaries and hierarchies lie and instead use the sessions as an opportunity to identify them in operation.

References


Kitzinger, J. (1994). The methodology of focus groups: the importance of interaction between research participants. *Sociology of Health & Illness, 16*, 103-121.


