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Informal Learning Amongst Pediatric Rehabilitation Teams – An Ethnography of Tea-Room Talk

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1. Introduction

Chris Baldry writing in his 1999 article 'space - the final frontier' states that for too long the built working environment has been excluded from analysis of work organizations (Baldry, 1999). One of the first things a newcomer to any organization has to learn is how to navigate within their new spatial environment. For example, what are the cues that signal territorial boundaries, and whether such territories are functional or hierarchical? If the question is asked as to how the built environment aids the extraction of surplus value then the work building is far from being a passive container. The building itself is a property and it houses technology. It facilitates managerial control over the labour process in both the co-ordination of production through the division of labour and the construction of systems of surveillance. Furthermore, the building is also said to influence behaviour through the messages it sends - the semiotics and symbolism of the built environment or a form of non-verbal communication. Hall's writings on non-verbal behaviour and proxemics (the use of space in communication) are influential environmental cues (Hall, 1959, 1966). Thus environments provide cues for behaviour and these cues reinforce what is socially appropriate or inappropriate. The above literature, therefore, suggests that environmental cues in the rehabilitation service unit promote certain behaviours around the creation and foundation of a tea-room. This behaviour is linked to Goffman's (Goffman, 1963, 1973) concept of identification and impression management whereby individuals manage the impressions others form of them in order to create and negotiate their presentation of self, in this instance in a public place (hospital service unit) and these by implication are linked to the health of staff members.

Space trends in the current health care design field both in literature and practice is to focus on "patient centred care" and "healing environments" (Mroczek, Mikitarian, Vieira, & Rotarius, 2005). It is recognized that good health care cannot be administered without health

care professionals and that burn out and stress may lead to reduced quality of health care. A supportive organizational and physical environment are both necessary for health professionals to work effectively and to take care of their personal health (Grandey, 2000). Congress themes of the 4th World Congress on Design and Health (2006 Frankfurt) included 1) design health facilities to allow for change and adaptability and 2) humanize health care environments for patients and staff (Carthey, 2006). There was no specific mention of spaces where teams can informally meet such as tea-rooms. In Australia the Department of Health Guidelines asks for staff rooms for staff respite, but does not dictate where these rooms are located <http://www.healthfacilityguidelines.com.au/>. In talking to architectural firms (personal communication – Bligh Voller Neild 2007) decisions around tea-rooms in hospitals are dependent on individual client briefs with the overall trend being for communal staff facilities for buildings, which encourages staff interactions and discourages silo-based teams and departments. According to Chastain “ It is imperative for clinicians and architects to work hand-in-hand in the design of all healthcare facilities, large or small” (Chastain, 2008, p. 1). Furthermore, Chastain states “The clinicians must be involved in the decisions for their respite areas. Location of break rooms¹, dining areas, lockers and education spaces must be convenient to their work area” (Chastain, 2008, p. 2).

Informal spaces in hospitals and what is enacted there also has been explored in the literature, as against the formal spaces of the ward, operating theatre, and clinic rooms (Heard, Roberts, Furrows, Kelsey, & Southgate, 2003; Iedema, Long, Carroll, Stenglin, & Braithwaite, 2005; Lancashire, Hore, & Law, 2003; Long, Iedema, & Lee, 2007). For example, corridors are acknowledged as spaces (public ones) in which consultations between clinicians occur (Heard, et al., 2003, p. 43) and ethical issues have emerged around their ‘publicness’ (Johnson, Cook, M.Giacomini, & Willms, 2000).

Clinicians’ tea-rooms, or common rooms, differ significantly from corridor spaces because they are not public spaces. Some clinicians’ talk might be similar, for example, time management, work flow planning, discussions on equipment costs and purchasing, knowledge and skill exchange, affective talk including social and ‘phatic’² communication, conflict resolution and reflections on attitudes and practices (Long, et al., 2007). The tea-room provides a spatial resource for the enactment and management of the complexity of everyday work practices (Iedema, et al., 2005)

2. Methods

2.1 Study design

The specific study we describe and analyse was part of a larger ethnographic study of the interactions between clinicians that was conducted in two pediatric hospitals in Australia (C Hunter, Spence, McKenna, & Iedema, 2008; C Hunter, Spence, & Scheinberg, 2008; C Hunter & West, 2010). Data collection occurred over a 12-month period between 2005 and 2006. Ethnography was chosen because it allows detailed ‘thick description’ (Geertz, 1973) of the everyday workplace practices of clinicians over a period of time cf. (Sinclair, Lingard, & Mohabeer, 2009).

¹Break rooms is a United States term which is equivalent to tea-rooms in Australia.

²Phatic communication = small talk that one hardly notices e.g. hello, have a nice day etc.

2.2 Participants

The rehabilitation service is located in a major metropolitan tertiary level pediatric teaching hospital affiliated with a local university. The service consists of an outpatient program of rehabilitation clinics and a small number of inpatient beds on the surgical unit of the hospital. The core rehabilitation team (the “team”) consisted of 50 clinicians and six administrative staff. Ethics approval was granted from one university and one hospital ethics committee. Recruitment to the study was voluntary and all rehabilitation staff agreed to participate.

2.3 Data collection

Observations, the immersing participation of the ethnographer and detailed descriptive field notes of activities of the rehabilitation staff were collected, based on qualitative methodological literatures such as Denzin (Denzin & Lincoln, 2005), Pope (Pope, 2005) and (Mays & Pope, 1995). Observations were conducted during working hours at the workplace. Observations, participant observation and interviews of various lengths occurred in the tea-room over the 12-month period of the study. The ethnographer worked in two other service units simultaneously. This allowed for comparisons between tea-room structures and different meanings for using a tea-room by staff and different dynamics of the teams that congregated there.

An inductive approach to analysis, a hallmark of qualitative research, was used (Janesick 2000). Initially, the task was to extract concepts to make sense of what was going on. Transcribed interview data was analysed using keywords to identify topics and themes. All the data were entered into The ETHNOGRAPH version 5.0 program (Seidel, Friese, & Leonard, 2006) and this facilitated data organization and retrieval and the identification of keywords, topics, and themes.

3. Findings

3.1 Initiation into the field

The ethnographer’s initiation to the rehabilitation team in 2005 was at a meeting of team clinicians organized by one of the hospital research investigators who was also one of the senior rehabilitation pediatricians. Having been introduced, the first question addressed to me from one of the case managers was: “Do you like cooking?” Puzzled, I answered, “Yes I like cooking.” (I was thinking - cripes, where is this going, I am here to do research to observe these people’s interactions with each other). [The case manager’s reply:] “Oh, good, ‘cos we like cakes here” (Phew! So that’s it). Nervous now, because of all the things I cook, cakes aren’t one of them. Will I have to do a crash course in cake cookery? Is it true that not only am I to enter a new field site but I have to enter with credentials other than those I already had?

In hindsight, the question was a light-hearted one, designed to make me feel at ease, a welcoming gesture. Little did I realize just how important cakes and the tea-room were to become in the project.

3.2 Tea-room activities

In the original hospital design planning the current tea-room in the rehabilitation unit was designated a doctor’s consultation room (see red circle and box Diagram 1). The original

design did not have tea-rooms in this section of Level 3 of the hospital. The only areas available for tea or coffee-making are at the other end of the building where there is a kitchen (circled in red on the diagram), and a meeting room (highlighted in yellow) in which hot water is available from a water boiler on the wall. None of the rehabilitation staff, except one, has an office near either of these drink outlets. In fact, the waiting room of the child assessment centre (highlighted in yellow in the diagram) almost divides the two zones 1 and 2 of Level 3. The major consultation activities of the rehabilitation team occur in, and around the series of consultation rooms (boxed in red in the diagram).

The present rehabilitation tea-room is an L-shaped room with a small basin, micro-wave, fridge, low table with lounges along two walls and stackable chairs. There is a variety of wall adornments, a white board, pin board, shelving, some cupboards and a telephone. Mornings and lunchtimes are the busiest and noisiest, while in the afternoons there is less happening in the tea room.

In this tea-room which is used extensively throughout the day there is a diversity of activity from flurry to stillness, from none to one or ten or more persons, from a quiet conversation between one or two to 10 or more, or several conversations happening simultaneously while some participants wash up, make tea and toast, microwave lunch, cut the cakes, store things in the fridge, write on the white board, read a magazine or their mail, answer or make phone calls when responding to a pager, and so on. Sometimes, the door is voluntarily and momentarily closed while something private is disclosed, something that does not, or cannot, be allowed to permeate the public corridor space outside the tea-room.

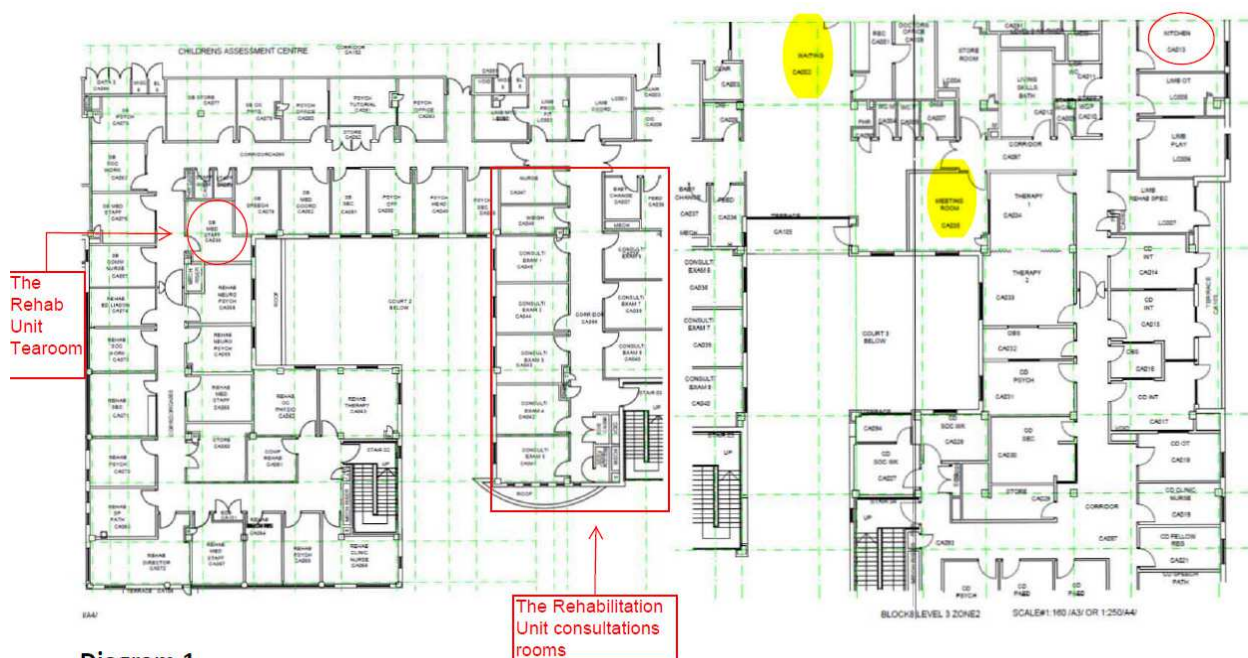


Diagram 1

Diagram 1. Diagram of rehabilitation unit level 3 zones 1 and 2

Because individual team clinicians come and go according to their individual needs conversations are said to be heterogeneous, i.e. conversations can move rapidly from one issue to another or from one clinician to another.

As well as the mundane activities such as addressing the needs of food and sustenance, the tea-room is a space where relationships can be nurtured. Co-workers can attend to and maintain relationships with each other (Sobo, 2009). For example, staff members' birthdays are celebrated with gusto. The birthday person is responsible for bringing a cake or some other delicious food, there is singing and conviviality on these occasions. The light-hearted conviviality and collegiality is reflected in the following:

"Oh look what J's put down for K's birth-weight and medical intervention" (M pointing to the white board where a list of predictions on the birth-weight, sex, name, medical intervention and predicted date of arrival of J's impending confinement) is being drawn up by work colleagues. Tea-room time is 'time out' from the busy formal work schedules. What is discussed there is ever changing.

Of the number of different activities that 'happen' in the tea-room, a great many of them are work related, for example, what happened at the clinic that morning; how are we going to organise a staff replacement. In particular, we will argue that having a space such as a tea-room to debrief, commiserate, relax and vent emotions, leads to better health and positive learning for clinicians. A tea-room or equivalent space precipitates effective interdisciplinary teamwork in this department. Following Long et al. the talk may be clinical, instructive, technological, organizational, affective and reflexive (Long, et al., 2007, p. 43).

Here are some excerpts of conversations taken from transcripts of tea-room conversations over a 12 month period, and analysed for their thematic content.

3.3 What's in tea-room talk?

3.3.1 Excerpt one theme 1

Appointment planning - administrative staff and rehabilitation paediatrician

The interaction is between the administrative officer and a staff specialist about the necessity or not of booking an appointment for a patient who required a repeat prescription before his designated follow-up appointment a few months later.

Admin officer: [Name of patient] ... we are not due to see him until October, you don't need to see him to prescribe do you or you do?

SS: *Yeah I really do, sorry, ... he's got to have his blood pressure and his weight checked anyway so they could go to the GP for that it's a big palaver I've got to send off documents to the HIC. (pause) ...*

You could do it as an half an hour appointment - a quick appointment

3.3.2 Excerpt two theme 1

Organizational planning - staffing issues

In this excerpt planning for a new staff member is being debated.

Senior staff 2: *Two days a week.*

Senior staff 1: *Two half days a week. Maybe we can stretch it to one and a half so it's maybe \$30,000 it's for half a year so 15 grand, there you are, not a huge amount of dough.*

Senior staff 2: *No, that's for sure.*

Senior staff 1: *I'll pursue that. I'll just check with [Name of another Staff member] Wednesday morning's ok too I think. It's the physical problem of rooms. Monday afternoon is our most flexible day it's good because we have piles of rooms*

Work gets done in the tea-room because the complexity and volume of collaborative hospital team-work coerces the team players to have 'opportunistic' interactions with each other. For example, Excerpt One, the interaction between the administrative staff member and the staff specialist could have taken place outside the administrator's office. All the administrative offices have glass panels which open onto the corridor. Excerpt Two could have taken place by phone or in either of the senior staff's offices. However, this tends not to happen because in this spatial context the clinicians' offices are at opposite ends of the unit and the tea-room is midway between them.

3.3.3 Excerpt three theme 2

Getting the big picture or extending professional boundaries

Networking, conferencing and exchanging information are all part of a day's interactions. The following excerpt transpires between the clinical nurse coordinator (CNC), the neuropsychologist, the administrative officer and a rehabilitation staff specialist. The discussion is about an overseas specialist who has come to (Name of pediatric hospital) rehabilitation, and the above staff specialist who had recently returned from a conference in the US.

CNC: *...Surgery, Mexican, and they do really good work; certainly from a spinal point of view they do really good spinal cord injury.*

Researcher: *So is [name of overseas specialist] attached to one of those hospitals?*

CNC: *Gillette children's hospital. [Name of hospital 2] is another one.*

Staff specialist (SS): *so [name of o/s specialist] is a neurosurgeon?*

CNC: *yes, she does sdr³ with [name of local neurosurgeon]*

Neuropsych: *I was at school with a Gillette. She used to get 'the best a man can get' (laughter all round)*

[Name of SS] *what was the conference?*

SS: *It was a bit of a [name of hospital 2] type meet. Everybody knew each other. I was like a real outsider. They were all [Name of hospital 2] people*

Researcher: *Did they know where Australia was?*

SS: *Just - there was one other Australian a surfer type from Victoria.*

The content of this excerpt is both social and humorous while simultaneously work related in two ways. First, the staff specialist is an interdisciplinary team member and the conference attended was for professional development purposes. The other team members

³ selective dorsal rhizotomy, a neurosurgical procedure

are asking questions about a section of the health system in the USA. Gaining information and processing this knowledge for future use is one way of learning about overseas professional practices.

3.3.4 Excerpt four theme 3

Reflexivity (the recognition that team members are involved in data production and consciously reflect on its meanings) -

A debriefing about a specific patient after a Brain Injury clinic; a teenage boy who was attended to by an interdisciplinary team (all work the consultation simultaneously) composed of a case manager, registrar and social worker.

Case manager: *Did you notice that a question that you asked him [Name of registrar] and he didn't know and so just immediately goes to Mum and says did I? Like automatically.*

Registrar: *Yeah.*

Social worker: *Before the clinic when I saw him by myself there were a couple of things I asked him and he said 'you'll have to ask Mum about that because she knows' . I said 'well, I have spoken to your mum but I want to know what you think.' You can [try to get the patient to answer for him/her], you have to have the time, initially take it slowly, ... in there but doing that in clinic you don't always want to do that. I saw a boy last week with [Name of rehabilitation pediatrician], a teenage boy younger than [Name of patient], with his mum and she spent the first probably ten to fifteen minutes talking about a litany of things he had been doing, rather than the case, and I watched him get really, really teary, nearly into his shirt and [Name of rehabilitation pediatrician] turned to him and said '... do you want to say something about what Mum's said and he was so choked up that the only thing he could have done next was cry so he kind of just sat there immobilized.*

This excerpt is rich in work practices reflexivity. The reflection on work practices is through retelling and revisiting the clinical consultation that occurred earlier in the day. These kinds of reflections occur often when interdisciplinary team clinicians eat their lunch or have a quick cup of coffee. It is the backstage dialogue that complements and expands knowledge sharing about the front stage formal clinical consultation. The difference between the backstage and the front stage is that in the latter each clinician has a specific professional role with accompanying tasks to perform in relation to the patient. In the backstage the individual professional identities become less significant as the collegiality of the group emerges in the informal social setting.

3.3.5 Excerpt five theme 3

Reflexivity (work flow and time management)

Registrar: *... I was agonizing at one point because you guys were doing really well and he [the patient] was opening up and lots of things Mum needed to say and I knew I had another patient in the waiting room who'd been out there half an hour*

Case manager: *That was fine, you just slipped out*

This excerpt captures the individual clinician's sensitivity to the consultation process. The registrar is mindful of how well the social worker and case manager were doing in eliciting

responses from the patient, after a slow start. She is mindful of other patients waiting and how long they have been waiting. She needs to time manage. An unobtrusive departure is negotiated and acknowledged by the case manager 'you just slipped out'. There is little or no disruption to the flow of the consultation at a crucial point where the patient was opening up. The registrar, although not as experienced as the other two clinicians, recognized their expertise in drawing the patient out.

3.3.6 Excerpt six theme 4

Affective talk

The outpatient team physiotherapist came to the tea-room in the Rehabilitation Department to report a mother was 'spitting chips' because her daughter had not had the tests and had fasted all day. How the story was retold in the tea-room is described in Fig. 1.

Physio	: (visibly tired and frustrated) <i>and I walked in to ... After I had all the seating ¹stuff done and ... this is hard work</i>
Staff Specialist	: (smiling) <i>just tell us the story, please</i>
Physio	: <i>Mum was obviously upset and I said: 'And how are you?' And she said: 'Don't even ask' And she got quite teary because she was quite upset earlier in the morning because [name of child] upset because she hasn't been fed and...² she just said: 'She hasn't eaten, she hasn't had breakfast, she hasn't had lunch, and we're still waiting for the MRI so now it's just been cancelled has it?'</i>
CNC	: (Name of Registrar) <i>got a call when we were on rounds before, saying that ... they couldn't fit her in, the MRI person, they couldn't fit her in, ... they had to cancel it and that she feels bad because they keep on fasting her and then it's cancelled.</i>
Physio	: (Name of patient) <i>has fasted all day (pause) all day ...</i>
CNC	: <i>... They physically can't fit them in, but they feel really bad, you know, I'd feel really bad about that but they just can't fit her in. ... Everything's fallen apart.</i>
Physio	: <i>this kid's fretting and ticking an'... I just don't know in ... (Name of place) ...I've just got to slip back down.</i>
Social worker	: <i>So is (Name of social worker) looking after her, (name of social worker)?</i>
CNC	: <i>She saw her on Monday afternoon. I don't know what other contact she's had... (Name of Rehabilitation Fellow) and I saw her for about an hour yesterday and um Mum was really quite teary then ...</i>
Physio	: <i>and when I went down there before I said: Why don't you just go for a walk, and you've got your phone and if the ward need to call you'</i>

1) This child is having a specialized seating system made. The physiotherapist had overseen this earlier. The child was extremely distressed at the seating assessment.
2) Having a general anesthetic requires the patient to fast for up to 4 hours before the procedure.

Fig. 1. Affective talk

This example of affective talk is the result of an incident involving an inpatient. In one sense it is an incident like any other mundane everyday work incident but the emotional labour of frustration it generated for team members was high. The staff involved were enabled to debrief and find sanctuary and solace in the tea-room talk by telling the story. This was particularly poignant for the physiotherapist who felt responsible for the situation that had arisen. By telling her story she expressed her frustration with a system (the hospital) that is stretched to the limit at times. The space allows individual team members the freedom to talk the affective talk. The talk is valued, even if unconsciously because it enables the individual a space to free oneself up from the affect - to disembodify it, to take a rest before moving back into the front stage again to become the professional managing damage control with the patient and family.

4. Discussion

There are two emerging dominant themes: a service unit tea-room is recognized as a valuable structural space for team communication structures (informal vs. formal), and backstage activities such as debriefing and informal learning are engaged in regularly during heterogeneous interactions (see diagram 1 re physical space of commandeered tea-room).

Space can be viewed as being both a physical site and a social space in which social relations are enacted. In this latter sense a site is ideologically demarcated and separated from other places. Different messages and communications take place there (Kuper, 2003) and values are attached to them. Sites are verbally and spatially identified. The reallocation of social and physical space results in a redistribution of space and the creation of new spatial foci (identity). In our study the reallocation of a demarcated doctor’s interview room to become a service unit tea-room by the clinicians themselves identifies certain values and meanings to that space. Over the time the ethnographer worked in the unit, in the internal orientation plans given to new registrars, the name of this space changed. For example:

The space was called:			
Original Plan	2005	2006	2007
3B Med Staff CAD56	FAMILY INTERVIEW ROOM	THE TEA-ROOM	THE TEA-ROOM
	Aka tea-room		

In social space social relations may include hierarchy, of professionals for example, this means space is also place at the individual or group level (hospitals).

“places come into being through praxis (activity), not just through narratives (spoken word)”

(Rodman, 2003, p. 207).

Having a space to call one’s own or territoriality is important for workplace identities (Kuper, 2003). Erving Goffman (Goffman, 1963), in analysing the micro-geographies of organizational life, defined social spaces as either front stage or backstage with each portraying different performances and different selves. For example, for restaurant staff the front stage is in the

dining area with the guests, the backstage is in the kitchen. A waiter displays different selves in these two adjoining yet different spaces. Backstages are likely to be less inscribed with conduct regulations and institutional prerequisites. Adams (2008) study substantiates this division of space. Her results demonstrate the importance of 'backstage' areas to refer to informal spaces in hospitals and their importance for "informal learning, social support and the unit's cohesion" (Adams, 2008, p. 3). We assert that the rehabilitation service unit tea-room illustrates some of the characteristics of Goffman's backstage. The tea-room as backstage away from the patients' requirements and demands which are front stage, creates space with time to relax physically, mentally and emotionally. Tea-room social interactions exhibit a change of pace to the day's work activities with informal, unstructured and spontaneous exchanges taking place. Finally, this backstage is an opportunistic space that enables clinicians to re-energize for the front stage to follow, i.e. more clinical consultations - thus establishing a healthy balance of everyday workplace activities.

The activities and verbal interactions of the rehabilitation clinicians in their tea-room is significant because there was 100% consent to the research project and almost all of the 56 rehabilitation clinicians and administration staff spend time there. The verbal interactions include conviviality, organizational planning, reflexivity, affective talk and emotional labour (Grandey, 2000) as with corridor work described in the literature (Heard, et al., 2003; Iedema, et al., 2005; Long, et al., 2007).

The observations of the clinicians' themselves about their tea-room reveal further dimensions of the value of tea-room talk; the size of the tea-room space was thought to be crucial in its encompassing heterogeneity. The space is not big, sometimes it is difficult to find a seat, but people will stand until a seat becomes available rather than depart the tea-room for another space. Clinicians feel that because they created this space for themselves by usurping another clearly designated space on the original hospital plans symbolizes success in the making. As mentioned earlier, there is a designated meeting room with tea and coffee-making facilities on the other side of the patient waiting room area (See diagram 1). However, it is removed from all the clinicians' offices and, as one long term clinician stated,

"Who wants to walk through a crowded waiting room to have a cup of tea and a break when patients are waiting for your services?"

The centrality of tea-room talk and activity is highlighted in the organization of the clinicians' work. Tea-rooms and hospital corridors (Long, et al., 2007) are not the only spaces outside of designated offices or consultation rooms where work gets done. Adams writes of "opportunistic communication and informal learning" (Adams, 2008, p. 12).

Lancashire et al. (Lancashire, et al., 2003, p. 62) state "the doctors' lounge was a source of medical education and social interaction as GPs and specialists met over a morning coffee before rounds." The tea-room is similar - a space where clinicians socially, educationally and professionally interact with each other about patient-centred care or any number of other topics that make up the dynamic unfolding of the day's events. Again, this is iterated in Adams thesis that shifting the focus from frontstage to backstage areas can enlighten our understandings of clinician fatigue, communication and quality of patient care. She specifically mentions "understanding the detail in communication and interaction patterns that occur in break rooms, lounges, cafeterias, enclosed med rooms, kitchens, locker rooms and utility rooms" (Adams, 2008, p. 110).

The informal and relaxed tea-room is in sharp contrast to the clinic or consultation context, the formal clinical diagnostic consultations or teaching and learning sessions as in lectures or formal structured meetings. It is backstage space that underscores a social focus but other foci occur as well. There is fluidity to the foci – social, professional or unstructured. These heterogeneous interactive sessions are important informal collaborative interactions in informal spaces where multidisciplinary teams congregate.

Contrasts extend to the use of hospital tea-room space in other parts of the hospital. Based on the ethnographer's five years experience of research conducted in hospital settings, the shared, larger tea-room located between the pediatric intensive care unit (PICU) and neonatal intensive care unit (NICU) has an invisible but well-known and acknowledged demarcation line drawn down the middle of the room when it comes to seating (C Hunter, et al., 2008). The Pediatric ICU nurse clinicians sit on one side and the NICU nurse clinicians sit on the other. The fridges, sink, lunch and snack-making facilities are shared spaces, but to sit down to eat one's lunch, read a magazine or watch TV are not. The administrative and cleaning staff sit at two round tables, occasionally registrars eat their lunch there and spasmodically a staff specialist might stop for a cup of tea. The occupants sit and read, use their mobile phones, watch TV or chat amongst themselves. The structure and this invisible demarcation has an effect on what is enacted there.

In another larger clinicians' tea-room visited once by the ethnographer, the physiotherapists' service unit tea-room, the occupants were all of the same profession or worked in the same department. The dynamics were differently enacted.

4.1 Informality and workplace learning

Learning at work constitutes a large part of adult learning (Boud & Middleton, 2003). The role of workplace learning in the context of patient safety and quality of care has not received the attention it deserves. The patient safety literature emphasizes the role of effective communication and good teamwork, but few compelling accounts are offered of what these phenomena look like (Runciman, Merry, & Walton, 2007; Vincent, 2006). When clinical processes are investigated in ethnographic detail and here we include tea-room talk, it transpires that clinicians engage in mutual, if informal interaction and learning on an ongoing basis (C Hunter, et al., 2008; C Hunter, et al., 2008).

Informality promotes social intimacy. For example, in Excerpt 4 Theme 3 peers or colleagues share their perspectives about how this particular consultation process unfolded. Others who know the family from previous times join in, or express opinions about past experiences around similar issues. It is about the recognition of work practice skills which encourage the participation of the parent and child to give their viewpoints, when and where and being alert to visible signs of distress or discomfort of the patient, and how to handle that and move on from there. Memory and experiential knowledge of this or other similar patients is provided by other clinicians' accumulated and tacit knowledge.

In Excerpt 5 Theme 3 it is the tea-room dialogue which allows a space for positive learning for the registrar from the more experienced team members. Their affirmation that 'you just slipped out' from the consultation affirms for them her sensibility to the consultation flow, the team's interprofessional collaboration (Sinclair, et al., 2009) and her perception of their expert engagement with the patient.

These ongoing kinds of learning exceed the structured opportunities for learning defined for clinicians' workplace learning (Colley, Hodkinson, & Malcom, 2003; Eraut, 2004) as in learning 'on the job' literally in a clinical consultation for example. Our account shows that horizontal or informal learning is crucial for enabling people to do their personal work while ensuring the quality and safety of clinical processes. Clinicians' work practices are becoming increasingly complex at a time when the patient population who need chronic care is increasing (Sobo, 2009).

The literature on organizational learning emphasizes that learning is both product (something learned) or the process that yields such a product (Argyris & Schön, 1996) - the dialogical⁴ process of tea-room conversations. For example, opportunistic interactions that occur around administrative planning inform and expedite the organizational activities that are part of any large hospital department.

5. Conclusion

Spaces such as the tea-room described in this paper have a backstage and informal quality that complements the front stage or formal quality of the rehabilitation team's professional clinical work.

Informal work practices in a designated structural space within a service unit enhance teamwork communication and efficacy of formal work practices.

Clinicians value the informality of the backstage because it provides sanctuary, a rearrangement of the professional and personal relationships and the opportunity for informal learning in the work place.

When clinical processes are investigated in ethnographic detail including tea-room talk, it transpires that clinicians engage in mutual, if informal, interaction and learning on an ongoing basis.

The tea-room backstage space is away from the intensive, complex and different world of the formal tasks and responsibilities carried out in the outpatient clinics, the ward rounds of inpatients and the administrative work each clinician is required to undertake in their everyday practices.

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⁴ Dialogical - characterised by dialogue

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The chapters presented in this book draw on ethnography as a methodology in a variety of disciplines, including education, management, design, marketing, ecology and scientific contexts, illustrating the value of a qualitative approach to research design. The chapters discuss the use of traditional ethnographic methods, such as immersion, observation and interview, as well as innovative ethnographical methods which have been influenced by the new digital culture. The latter challenges notions of identity, field and traditional culture such that people are able to represent themselves in the research process rather than be represented. New approaches to ethnography also examine the use and implication of images in representation as well as critically examining the role and impact of the researcher in the process.

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