Chapter 15

Learning in and about teams

This chapter focuses more specifically on how teams can learn to work together and education that facilitates developing skills for collaboration. In particular I discuss the concept and context of interprofessional education (IPE) and its role in understanding and working together within a values-based framework. There are two examples of interprofessional learning activities for practice teams.

Reflection point

Consider what you already know about IPE. Do you know of any definitions of IPE? In your own career how have you learnt the theory behind and skills for teamwork? Did this learning ever include outcomes relating to values-based practice?

One of the perplexing features of contemporary health care professional education, both before and after qualification, is that there is still comparatively little learning in and about teams, teamwork and collaborative practice. This is in spite of the growing awareness of the need for and development of teamwork in health care. Skills for teamwork, leadership and collaborative practice do now appear as core competencies in many health professional curricula. Some of the learning to achieve these outcomes does take place in groups and teams; some of the learning is multiprofessional and some interprofessional (Box 15.1), but summative (endpoint) assessment for qualification or registration is always of the individual. In my experience, rarely is there specific mention of values in current health professional education: individual, team, organisation or values-based practice.

Your own education

Depending on your age, experience and the year you qualified, you will have had none, some, or a great deal of interprofessional education through interprofessional learning (IPL) or more likely multiprofessional (Box 15.1). If you have experience of IPE, consider when this happened, with whom you were learning, what the intended outcomes of the learning were and whether these were achieved. Did you enjoy the activities? What would you have changed about the session/programme/workshop etc, if you were going to participate again or even run a session yourself? Has there been any other time when team work was a specific learning outcome in your education or continuing professional development (CPD) activities? How

have you developed your ability to work in or lead a team? Were values ever mentioned in an educational activity?

Box 15.1: Definition of IPE and IPL

- Interprofessional education (IPE): The definition that is now commonly used internationally is that of the Centre for the Advancement of Interprofessional Education (CAIPE). The 2002 version states that IPE occurs: 'when two or more professions learn from, with and about each other to improve collaboration and the quality of care' (CAIPE, 2002). 'Professions' usually refers to health and social care, but can include other professions that collaborate to improve health and well-being such as education and law. The learners within the professions may be pre-qualification students and/or qualified practitioners. The prepositions 'from, with and about' are important as they imply that learning is shared, interactive and equitable, rather than just in common and passive. Interprofessional may be contrasted with multiprofessional education, which involves the professions learning side by side without interaction (also known as common learning).
- Interprofessional learning (IPL) or shared learning: Learning arising from interaction between members (or students) of two or more professions. This may be a product of interprofessional education or happen spontaneously in the workplace or in education settings (Freeth et al., 2005).
- In contrast multiprofessional learning (or common learning): the learners from two or more professions learn together without planned interaction to cover a common topic.

Your own experience of learning will certainly colour your recommendations to others about how they should learn. But some of the most powerful influences on your subsequent working practice will have been the people you learnt with, from and observed in the clinical environment. As we have explored in earlier chapters, values are shaped by many different influences. A health professional student absorbs professional values through role modelling and what has been called the hidden curriculum as previously mentioned in chapter 1.

Health professionals as educators

Health professionals are role models in the workplace whether they have an explicit contract to teach or not. So we could say that health professionals are constantly affecting learning. Junior professionals and students watch what is going on around them. Indeed students frequently do not have specific tasks other than observation in their early clinical rotations. Before entering the clinical environment, students will most likely have been taught about appropriate professional behaviour at university, during what are commonly referred to as personal and professional development (PPD) modules. They may have discussed values, but certainly will have been taught about ethics and ethical dilemmas. Hopefully, they will have been reflecting on their own values and whether these are appropriate for health care practice. Some students and junior staff reflect more than others. Some need to be facilitated to consider values and how their behaviour impacts not only on patient care but also on their peers and senior colleagues.

In personal and professional development programmes at university students are often given scenarios to discuss that have examples of 'good' and 'could do better' professional behaviour. When they have been on clinical placements, they may be asked to bring their own stories back to discuss in small groups. The professionalism of the clinicians they observe is rooted in their values. How professionals work with each other, how they communicate, what

they say about other professionals, their interpersonal skills and their attitudes to team work are all on view and noticed by students and juniors.

Teamwork learning activities

A high proportion of our professional learning these days takes place in small groups and this is also true of prequalification training. While lectures are still common and cost-effective for transmitting information to a large number of people, small group teaching is often preferred as it fulfils more of the requirements for adult learning as described by Knowles (1990) (Box 15.2). This may be problem-based, case-based or task-based learning. A good group facilitator will help members understand that group processes are similar to team processes within working environments. The facilitator will also reflect back to the group how they are working together and what could be improved, relating this to clinical teams.

Box 15.2: Principles of adult learning

- Adults are autonomous and self-directed: they should be encouraged to set their own learning outcomes.
- Adults require facilitation rather than didactic teaching.
- Learning is best built on the learners' life experiences and existing knowledge; they should connect the learning activity to their current knowledge and skills.
- As adults are goal-orientated they want to know the purpose of the activity.
- They need to be motivated and understand the relevance of learning activities to their practice.
- Adults need to be stretched and receive constructive feedback.
- Adults need to be shown respect by the facilitator; they should be treated as equals in the learning environment.

Traditionally problem-based learning (PBL) and case-based learning (CBL) use problems and patient cases respectively as triggers for finding and working with information. However, educators now employ PBL and CBL in diverse ways and it is sometimes difficult to distinguish between them. One definition of PBL is 'learning that results from the process of working towards the understanding of a resolution of a problem. The problem is encountered first in the learning process' (Barrows & Tamblyn, 1980, p. 1). In contrast CBL has been defined as using a guided inquiry method, with defined learning outcomes, thus being more structured than PBL (Srinivasan et al., 2007). At university problems and cases can be written to meet not only science and clinical learning outcomes but ethical and professional outcomes, allowing discussion and reflection on challenging topics.

CBL is also referred to as case study teaching and case method learning. The Harvard Business School (HBS) adopted the case method across its curriculum in 1920 and it is still used today. Its website includes the following: 'when students are presented with a case, they place themselves in the role of the decision maker as they read through the situation and identify the problem they are faced with. The next step is to perform the necessary analysis – examining the causes and considering alternative courses of actions to come to a set of recommendations. To get the most out of cases, students read and reflect on the case, and then meet in learning teams before class to 'warm up' and discuss their findings with other classmates. In class – under the questioning and guidance of the professor – students probe underlying issues, compare different alternatives and finally, suggest courses of action in light of the

organisation's objectives' (Harvard Business School, 2011). From this description it is obvious that this method of learning aims to mirror team working in practice and team meetings where decisions are made after considering options and, if appropriate, the patient's goals and expectations. HBS emphasises on its website the importance of values and expects students to share the community values of mutual respect, honesty, integrity and personal accountability.

Queen's University Centre for Teaching and Learning (Ontario, Canada) states that CBL 'focuses on the building of knowledge and the group works together to examine the case … the students collaboratively address problems from a perspective that requires analysis. Much of case-based learning involves learners striving to resolve questions that have no single right answer' (Queen's University 2011). Again the parallels with clinical work are obvious. However PBL and CBL often take place with uniprofessional groups, though as learning methods they are extremely suitable for IPE.

Depending on the learning outcomes, cases may be based on patient histories, but they can also focus on more specific issues relating to teamwork: cases of dysfunctional teams, or examples of adverse events arising from poor teamwork and communication. The scenarios in this book, for example, would make good triggers for discussion, and we may call this type of learning 'scenario-based learning'.

What is important for this type of learning is to define clearly what you expect the learners to learn – their learning outcomes. Too often these are forgotten, and participants may query the need to learn together, a process that may be difficult to organise logistically. Examples of frequently defined learning outcomes are listed in Box 15.3.

Box 15.3: Examples of learning outcomes for IPL activities (Thistlethwaite & Moran, 2010)

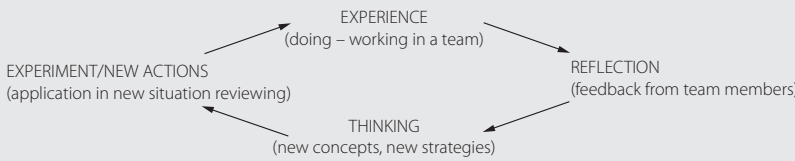
- Teamwork – *Knowledge of and skills for*.
- Roles and responsibilities – *Understanding of professional boundaries*.
- Communication – *Awareness of difference in professionals' language*.
- Learning/reflection – *Reflect critically on one's own relationship within a team*.
- The patient – *Demonstration of the patient's central role in interprofessional care*.
- Ethical/attitudes – *Understand one's own and others' stereotyping*.

Experiential learning

Reflection on group or team processes during learning is important. It helps to link the theories of teamwork and team function with the practical: what happens, or what should happen, in health care practice. Young health professional students, many straight from school, will have had limited experience of working in teams, though most will have been involved in sport (team based) or music (orchestra) and can draw on this in discussion. Experienced health professionals learning together bring a wealth of experience to share, and it is this experience that should form the basis of learning – building on what is already known. When working through a learning activity, the learning is more powerful if based on an example from a group participant. If the group is an actual health care team, the members can work through examples of current or past issues to discuss how they work together and how they might improve. Examples of this are significant event analysis as we have seen in Chapter 4, but teams should also work with examples of what has been done well and why.

We learn teamwork best by observation and practice, and reflection on that observation and practice, with feedback from others if possible. The theory behind such small group work is based on adult learning theory as described above, and here also known as experiential learning, i.e. learning through experience. The experiential learning cycle of Kolb (1993), derived from the earlier work of Lewin, explains the process (Box 15.4). While a learner may move round the cycle in a workplace, the process is also possible within a more structured team-based learning session. The observation and reflection is now no longer an individual process but also involves other team members, adding value to skill development (Elwyn et al., 2001).

Box 15.4: Kolb's experiential learning cycle in relation to teamwork



Reflection point

How do you learn? How do you keep up-to-date? Do you prefer to learn by yourself or do you find a group learning process more rewarding? If in a group, would you choose a uniprofessional or interprofessional experience? Consider the process of reflection. How often do you reflect on your learning and how you have learnt?

There follow two examples of team-based learning activities. The first specifically focuses on values-based practice. The second is a case-based experiential learning session using role-play with the help of simulated patients.

One: A team training session for VBP

Rachel Meers is an experienced health care educator and interprofessional facilitator. Her own professional background is speech therapy but she has not worked as a clinician for 10 years. She has been asked to run a professional development session for the Sunshine Group Practice, a six doctor general practice in a deprived area on the outskirts of a major city.

Reflection point

What qualities, capabilities and values would you look for in an interprofessional facilitator for your team? Check these against Box 15.5. Do you think it is important that the facilitator is or has been a practising health professional? Why/why not?

The practice manager (Sunita Patel) and the education lead for the practice (Dr Lawrence Pope) would like a session on team work, particularly as the practice has several new members of staff and there is a feeling that communication and collegiality is not as strong as it could be. There has been some confusion as to which professional is responsible for what, and

Box 15.5: Capabilities required for interprofessional facilitation (adapted from Howkins & Bray, 2006)

- Generic facilitation skills.
- Reflective practice.
- Awareness of potential role conflicts.
- Interprofessional values.
- Open mindedness.
- Ability to challenge stereotyping.
- Ability to give constructive feedback.
- Acknowledgement of power and status issues within health care teams.

tension has been rather high. Rachel agrees to run an afternoon session for the wider team and there will be doctors, practice nurses, a nurse practitioner, practice counsellor, health visitor, one community nurse (more have found it difficult to free up time), receptionists, medical secretary and the practice manager. Lawrence and Sunita have briefed Rachel before the session and stressed how important they feel it is to have the team discuss how they are working together, problems they are facing and how things might improve. They also consider it important, as there are new staff, to re-visit the values of the practice and their commitment to the community.

Reflection point

Consider at this point what it is important to tell the staff about the session. They should have some idea about what the expected outcomes are but there should be flexibility for them to define their own problems and learning needs. If you were facilitating such a team learning activity yourself, what would you be considering about the process and what might be potential problems? As the facilitator what would you like to know about the practice, the team and the team members?

Looking at the make-up of the learning group and, without knowing much about this particular team's dynamics and values, or the individuals' values, Rachel will be wondering how comfortable various members may be in discussing what could be sensitive issues. Who are the new members of staff? Are they used to interprofessional education? Have the receptionists been involved in such activities before? Given that their 'bosses'/line manager are present, will they feel able to participate fully? How will the various professionals and administration staff learn and work together?

There are a number of ways that Rachel can run the session. Below is just one example. Rachel starts with introductions and asks participants for their expectations of the session (before this she will have been noticing who is sitting where, who is talking to whom etc). During the introductions she will observe who appears to be comfortable, who says a lot and who is quiet. She will then discuss the ground rules for the afternoon, asking for suggestions and again noticing who speaks first and longest. Ground rules may include: not interrupting colleagues when speaking, being respectful, turning off mobile phones, everyone to participate in discussions, confidentiality. Having considered what the group wants to achieve, she will adapt her plan to encompass this as well as to achieve the goals that Sunita and Lawrence have identified. She will list the proposed outcomes and check that there is agreement (Box 15.6 lists examples of possible outcomes). It is important that the outcomes for the

session are clear to facilitate the learning process and help the participants know what they should achieve.

Box 15.6 – Examples of learning outcomes for a team-based learning activity

- An understanding of the term 'values'.
- An agreement on the practice's values.
- An exploration of how values might impact on our work.
- Exploration and discussion of team members' roles and responsibilities.
- Recommendations for any necessary changes in how we work together.

The first exercise will be a discussion of the practice's values – not forgetting that some of the staff are not directly employed by the practice but that they work with the same patients/clients. Rachel splits the participants into smaller groups ensuring that there is a mix of professions and roles within each group. Some of the more reticent participants may find it easier to contribute like this rather than have to address the whole room. The exercise is helped by trigger questions (Box 15.7). The groups then report back on the main points of their discussion to the larger group and Rachel ensures a consensus is reached. She also asks them what they have learnt from and about each other: did anything surprise them in the group discussion? Were there any differences in professional values?

Box 15.7: Trigger questions for the first activity

- What are values?
- What values do you/we bring to work? (personal and professional values).
- What are our team's values?
- Do we all agree with these values?
- Do we want to change these?
- Would these values fit with what our patients expect?

For the second activity of the afternoon Rachel asks people to think of one example of an incident in the practice, which exemplifies these values, and one incident where things could have been done better, where the values were not upheld. Just in case no-one volunteers any ideas, Rachel has been primed by Lawrence with two scenarios, but in fact the team, now warmed up, have several episodes they wish to discuss (Box 15.8). Rachel breaks them into mixed groups again with trigger questions (Box 15.9) to discuss and reminds them that this exercise is not about blame (though praise is fine) but about learning from experience: both good and not so good.

The incidents may appear minor, but they are the day-to-day issues that are rarely discussed at formal practice meetings, which are generally reserved for bigger problems relating to patient safety and adverse events.

In the de-brief several people mention that they are unclear about each other's roles. It is apparent that there has been some ill feeling when people are asked to do tasks that they do not feel are within their remit. Sometimes the tasks are beyond their scope of practice or capability; sometimes the tasks are 'beneath them'. This generates discussion about best use of people's skills but the consensus is that if necessary anyone should be prepared to do a 'lowly' task if it is necessary and there is no-one else to do it.

Box 15.8: Incidents for discussion

- **Incident 1:** Josie (practice nurse): I was running over 20 minutes late one morning. I called in my next patient and apologised for being late. He said: 'you are the first person in this practice who has ever said sorry for being late'. While punctuality is a value of course we cannot always be on time, but the receptionists should keep patients informed if we are running late, and I certainly think apologising doesn't hurt.
- **Incident 2:** Alice (GP): I have been seeing a 78 year old lady with multiple health problems for several months. Last week I saw she had developed a nasty ulcer on her right ankle. I haven't really had to deal with this sort of condition for a while but I remembered that Janice (one of the practice nurses) had been on a course recently about trauma, skin problems and new methods of treatment. We did a joint consultation with the patient and Janice really taught me a lot about the types of dressings I could use and follow-up care. I think working together like this is wonderful. [Janice adds that in her previous practice the doctors rarely asked her advice about anything and she finds it refreshing that the GPs here have no embarrassment about acknowledging that the nurses have a different and complementary skill set.]
- **Incident 3:** Joe (junior receptionist): I booked in a mother and her young son for an appointment with Janice, but I was told that it was more appropriate for the health visitor to deal with this type of problem. I don't really understand the distinction between what the different nurses do and would like some information for this and to give to patients so they can also decide who to see.
- **Incident 4:** Cheryl (medical secretary): I was in reception the other day and some of the staff (including a doctor, a nurse and a receptionist) were talking quite loudly about what they had got up to at the weekend. It's good to have a team spirit and be interested in one another, but what will the patients think? I didn't say anything because a GP was there and should know better.

Box 15.9: Trigger questions relating to incidents

- What happened?
- What have you/the team learnt from this incident?
- What values does this incident illustrate?
- How might things be done differently?
- How might the team improve following this incident and the discussion?
- What is the benefit of discussing incidents like this?

During the session Rachel ensures that she is meeting the agreed outcomes from the beginning of the afternoon. In the last half hour she revisits these and asks people whether their expectations have been met, what they have learnt, what has surprised them and what they might want to cover in another learning afternoon.

Two: Working with simulated patients

Simulated teamwork exercises are now an important part of both pre- and post-qualification health professional training. It is important to develop a scenario that is authentic, either based on an incident that has happened to students or participants within a clinical setting, or that is a common experience within health care settings that professionals need to be able to deal with.

Simulated patients are people, not necessarily professional actors but often so or recruited from amateur dramatics groups, who are trained to portray patients in a partially scripted scenario and who are able to respond authentically to the interactions they have with health professionals and/or students during learning activities (Box 15.10). They are able to give feedback in role to help learners enhance their skills and meet defined learning outcomes. Learning via simulation is a specialised method of experiential learning, allowing rehearsal, experiment, repetition and feedback, with both reflection on action and reflection in action.

Box 15.10: Benefits of working with simulated patients (from Thistlethwaite & Ridgway, 2006)

- Facilitator and learner have some control over environment.
- Can plan specific learning outcomes by use of scenarios unlike opportunistic consultations in real clinical settings.
- Ability to stop consultation/scenario at learning points if patient/learner distressed.
- May re-run consultation/scenario to try different strategies.
- Immediate feedback from patient or 'simulated professional'.
- Feedback from group.
- Learners can practise difficult consultations without risk of upsetting real patients.
- Scenarios may be developed in response to learner's needs.

Rachel returns to the Sunshine Medical Practice 4 months after her previous visit. This time she is accompanied by two simulated patients: Roger and Bryony. Lawrence has briefed her a few weeks ago about some incidents at the surgery, which he would like to re-run with the staff so they will feel better equipped to deal with similar problems in the future. To avoid ruining the element of surprise with the scenarios the staff are only given some broad learning outcomes (Box 15.11) prior to the session without any details about the simulation that is about to unfold. They are aware, however, that the session will involve a simulation. There is also a discussion of the guidelines for giving feedback (see Chapter 3, Box 3.2, p. 120). Two camcorders are set up: one in reception and one in the treatment room.

Box 15.11: Learning outcomes for the simulation

- To enhance team skills in difficult situations.
- To reflect on and gain a better understanding of one's own and one's colleagues' roles and responsibilities in difficult situations.
- To discuss and improve communication between team members.
- To reflect on the practice's values as reflected in the scenario and how these affected behaviour.

The scenario begins in the reception area (the surgery is closed for the afternoon as protected learning time). Everyone has been primed that the patients involved in the scenario are 'registered' patients of the practice. Joe and Christine, two of the receptionists, are behind the desk. Bryony is seated in view of reception. Roger enters the surgery – he is unshaven, scruffy and smells of alcohol. He demands to see a doctor straight away.

Christine offers an appointment for later that evening but Roger continues to demand he is seen 'now'. Joe leaves to find one of the health professionals. Meanwhile Bryony gives a moan, clutches her chest and falls to the floor. So the team have to deal with two 'emergencies', decide who does what and prioritise the tasks. While the GPs and two of the practice nurses treat Bryony, Sue (nurse practitioner) takes Roger into one of the consulting rooms with Joe

(as a 'chaperone') and works through an interaction with Roger demanding a prescription for benzodiazepines.

The scenario runs for 20 minutes. Rachel then brings the team together and runs a feedback and debriefing session. They watch some of the recorded events. The ability to watch and reflect on what actually happened is an important part of the experience. 'I didn't realise I was just standing there doing nothing for so long' says Christine. Sue comments that she had really wanted to work with Bryony, whom she felt had greater medical need 'and was more deserving of my attention'. But having watched the play-back she now realises that her skills were put to very good use in dealing with Roger, who needed to be calmed down and taken out of the vicinity of the team working with Bryony. 'I was the best person at the time to interact with Roger. Division of labour within the team is important. I've lost my initial almost resentment of not being involved in the serious stuff of resuscitation, for which I'm trained, because I now know I also did a valuable job. We need to get our priorities right so we are all doing what is necessary.'

There are several areas in which the participants feel they could do better. In relation to managing Bryony's collapse, there was some confusion as to who should do what, and so they run through the event again. They also do this a third time with only one nurse and one receptionist (the receptionists have been trained in CPR). Sue does not feel she has handled her aggressive patient well and watches one of the experienced GPs interact with a very angry Roger. She then goes through the scenario again and feels more confident that she will defuse a similar situation more competently in the future.

There is a discussion about how the overall scenario and the teamwork reflect the values of the team. The team has never learned in this way before. They feel that this has complemented the discussion of the previous facilitated session, which focused more on talking together.

The evaluation of the session is very positive. The participants feel they have a better understanding of who should do what. Moreover the health professionals state that they now have a greater understanding of the skills and role of the receptionists as the frontline staff. What have they learnt about each other's values? The word that keeps being mentioned is 'professional': being calm, not flapping, ensuring the safety of both the team and the patients. Sue sums up the mood of the team: 'How can we work together if we don't learn and practise together? We have done our CPR training on manikins, but this added an extra dimension to practice and I now have a greater respect for my colleagues. Let's have more of this'. Joe comments that he had been angry himself at the way that Roger talked to both Bryony and Sue, and thought that there should be a practice policy that no-one under the influence of alcohol should be allowed to have a consultation. But he also realises that refusing to interact with Roger may have escalated the potential violence of the situation and that by involving another team member the situation could be defused. Keeping the team safe needs to be balanced against the needs of the patients; defusing a potentially dangerous situation by good interpersonal skills requires practice and experience.

Reflection point

Have you been involved in any teamwork simulation like that described? How do you think these activities help? What are the advantages and disadvantages of this type of education?

While working with simulated patients adds an extra dimension to learning, team members can work through interactions via role play to improve communication discuss and values.

For example, if we look at incident 4 in Box 15.8, Cheryl could role play giving feedback to the others in regard to their behaviour in reception. She may find this difficult in terms of the interaction with the doctor, but good facilitation will enhance her confidence.

Evaluation of learning

Reflection point

How would you evaluate a learning activity such as the one described? How do you know if the time was worthwhile for everyone, apart from by re-visiting the outcomes as described above?

Evaluation is important but can become tiresome especially if people do not feel that their evaluation is listened to or leads to change in the next education session. For example, if the participants say there is too much input by the facilitator and not enough discussion, this should be remedied.

There are two main categories of educational evaluation: process and outcome. Process evaluation, as it suggests, looks at the process of learning – how did the group interact; were the participants engaged; did most people contribute; did anyone appear to be drifting away? Such evaluation usually requires an observer, though an experienced facilitator may be able to fulfil both tasks if necessary. However, the facilitator may have unconscious bias and want to come across as having performed well (conflict of interest).

Outcome evaluation explores what participants have learnt during an activity and what effects that learning has on their knowledge, skills or behaviour. A commonly used framework for outcomes evaluation is that of Kirkpatrick (1994), which may be adapted for use with particular types of learning (Box 15.12).

Box 15.12: Different levels of evaluation (modified from Kirkpatrick, 1994)

- **Learner satisfaction:** Did the participants enjoy the session(s)? Were they satisfied with the content, delivery, pacing, scenarios, feedback and facilitators?
- **Learning outcomes:** Did the participants learn anything? Were they satisfied with the learning outcomes and were these met? Did they improve their skills or modify their attitudes?
- **Performance improvement:** Longer term evaluation. Did the learners change their behaviour as a result of the activity? Are they using their new skills in their workplace? Are they working better as a team?
- **Patient/health outcomes/organisational change:** These are the most difficult to evaluate and are therefore often left out. Has patient care improved as a consequence of the learning activity? Are things done differently in the workplace?

Communities of practice and their relevance for interprofessional learning

I would just like to mention here another term for the process of learning that has been applied to interprofessional activities. There is a great deal of commonality between them all with predominant foci of interaction, authenticity, experience and reflection.

'Situated learning theory' arises from the work of Lave & Wenger (1991) and their concept of communities of practice. Situated learning is the process by which we learn from our

environments, interactions and work/social contexts, and fits well with the apprenticeship model so common within health professional education and development. From this theory we derive the process of 'legitimate peripheral participation' of those learners who are newcomers to the team, which Day (2006) has described clearly. The learners are legitimate as they are potential members of the health professional community (in general) and this particular team; they are peripheral as not yet fully involved in team activities; they participate in team activities and therefore learn about their profession, the team and their role within it by engaging in work.

All new team members are learners even though they may be fully qualified professionals. Not all are able to be peripheral as they orientate to their new team's values and practices, but this model helps us reflect on how new members learn from the role models within the team and cannot be expected to 'know everything' from day one.

Conclusion

A team does not come fully formed and functional into the workplace. Basing learning activities within the team, rather than professional development always being undertaken in uniprofessional groups, is an important part of team development. There is facilitated time and space to discuss values, roles, responsibilities and goals.

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