Chris Walsh: DESPOL: Final Assignment
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What to do with FOAMed: Organisational Culture and Open Educational Resources

Contents:

Introduction

The rise of Open Educational Resources (OERs) simultaneously engenders conflicting attitudes of excitement and scepticism. Research from disparate fields tends to valorise OERs, especially their ability to transcend social and economic barriers (EC Report 2013, High Level Group 2014). Despite these proclamations OERs also pose a series of 'wicked problems' (Clegg *et al* 2011) when attempting to embed them into the strategy, culture and identity of learning organisations, especially as culture itself is an abstraction (Schein 2010). The principles informing OERs tend to be very noble, especially in learning contexts where collaboration is increasingly rivalling competition as a core institutional value (Clegg *et al* 2011). But the diversity of OERs can be difficult to assess, embed and credentialise, especially within cultural paradigms that are equally heterogeneous (Jones 2004).

This essay will discuss how an organisation can harness its progressive culture in order to embed OERs within its practices, discourses and artefacts. Specifically I will address the struggle to legitimise OERs within official organisational documents; I will propose that this can be done by explicitly embedding OER resources in the curriculum, and by offering a tailored and institutionally-approved space for learners to reflect on their engagement with OERs.

The organisation in question is the Royal College of Emergency Medicine (RCEM), a UK-based medical college responsible for the training, education and continued professional development of Emergency Medicine (EM) physicians of all professional levels. The OER in question is the RCEM FOAMed Network (RCFN), which is part of the burgeoning Free Open Access Medical Education (FOAMed) movement. The remainder of the essay will be divided into a series of sub-sections; the first will define FOAMed and explicate the organisational context; I will then work through some approaches to organisational culture (Schein 2010, Martins and Terblanche 2003) which illustrate how the organisation can harness its innovative potential; the concept of resilience **(**Weller and Anderson 2013) will also be considered here. Some solutions as to how FOAMed can be incorporated into reflective practices (both individual and institutional) and the official documentation of the organisation will then be proposed. Although not insurmountable, notable barriers and challenges, especially related to certification of learning and digital governance, will be acknowledged before I conclude.

Definitions of FOAMed and Organisational Context

The FOAMed movement is part of the overarching global OER community. OERs are categorised as multi-modal learning resources in the public domain to use, share and re-model in a rich variety of contexts (UNESCO 2012, cited in EC Report, p 5). Weller (2014) maintains that clear licensing for re-use underpins a key tenet of the OER ethos. OERs can help organisations promote or expand their brand and identity, and they can bring a sense of community to environments characterised by instability, which is certainly true of EM (Jones 2004, Schein 2004).

Part of the reason why FOAMed has flourished in the EM community is the correspondence between busy clinical environments and the rapid pace of production and dissemination of FOAMed resources. The nature of the specialty demands resourcefulness, innovation and sceptical critique, and FOAMed has emerged as a medium to assist these practices. In this respect FOAmed contemporizes rather than replaces traditional aspects of medical education, and it also ensures clinicians are more

well-rounded as there is an equal focus on clinical and non-technical skills (Roland and Brazil 2015). FOAMed content is comprised of podcasts, vodcasts and blogs published under licenses that encourage sharing and dialogic exchanges; there is also a strong organisational emphasis on producing high-quality work to ensure academic rigour and clinical relevance is maintained (RCFN Editorial Group Minutes 2015). FOAMed resources also suit a speciality impacted by rotas, shift work and multi-located teams, which makes scheduling traditional teaching time incredibly difficult (Nickson and Cadogan 2014)**.** The open nature of the resources also facilitates flipped classroom models and ensures resources are aligned with the expectations of our learners; it also encourages active learning (EC Report 2013). RCFN resources contemporize the evolving narrative of EM and provide a 'discursive space' for clinicians to operate in (Jones, 2004, p 498). It is context-specific, it sheds light on the 'entangled practices' of the specialty and (as all content is mapped to the curriculum) the site provides a running metacommentary on the curriculum itself (Hannon, 2011, p 168, High Level Group 2014). The medium of delivery ensures the gap between technology and pedagogy is narrowed as the RCFN demonstrates that OERs can be both educationally robust and technologically innovative (Hannon 2011).

The decision of the RCEM to embrace the FOAMed movement is testament to the innovatory spirit of EM. This is reinforced if we consider the elearning provision of other colleges and faculties who are members of the Academy of Royal Colleges (AOMRC), the regulatory body who oversee the activities of medical colleges. The AOMRC has twenty-two members and all but three deliver their elearning through the E-Learning for Healthcare Platform (E-LFH), the VLE developed by the Department of Health. Colleges who do not have a presence on E-LFH are located in the Republic of Ireland and Scotland so are subject to slightly different political and cultural narratives. The RCEM does maintain a presence on E-LFH but it also has its own VLE (RCEMLearning) which operates

alongside the FOAMed network, which means the RCEM are the only AOMRC member to be in this position[1]:

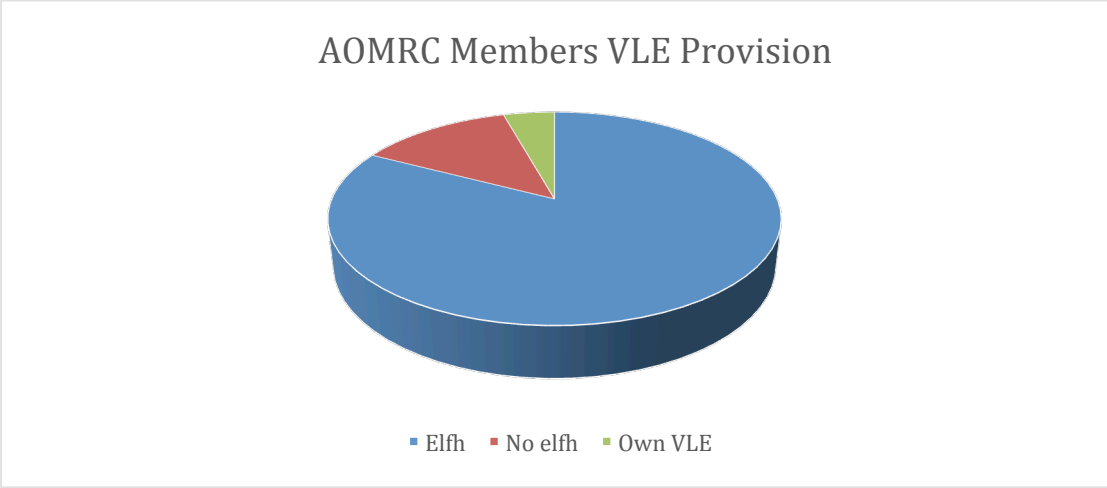

Figure 1: AOMRC members VLE provision

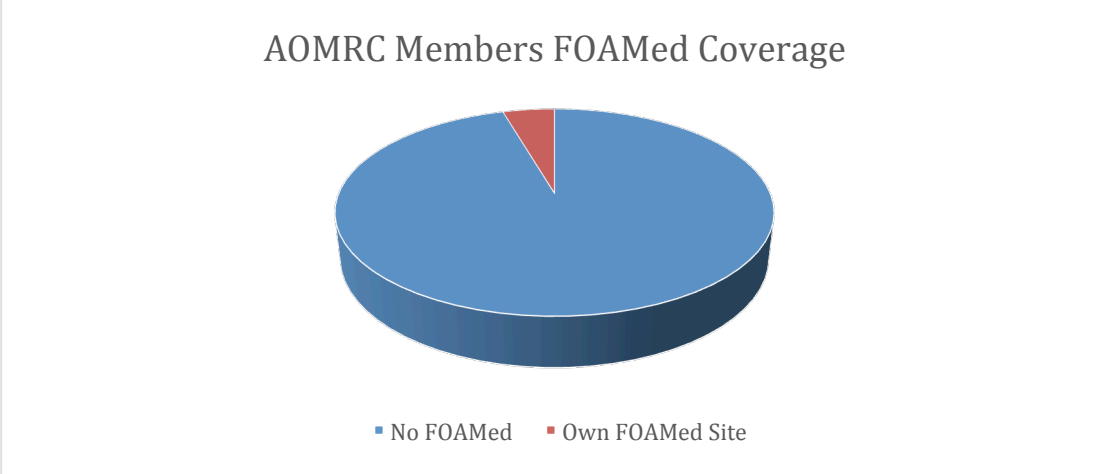

Figure 2: AOMRC members FOAMed coverage.

The RCEM is the only college to have its own VLE and FOAMed site, which evidences an appetite to embrace risk and innovation (Martins and Terblanche 2003). The decision to develop its own VLE alongside the E-LFH platform was taken in the mid-2000s and although this VLE is no longer available the genesis of the RCFN was partly due to organisational frustrations with the spiralling costs of the previous VLE, and anecdotal reports of poor stakeholder engagement. The RCFN was therefore an attempt to re-engage with stakeholders who felt disillusioned with the

[1] Information for charts available from the AOMRc and e-lfh sites

college's elearning portfolio. It was launched in September 2014 and it publishes content (podcasts or blogs) on a weekly basis; all content is published under a Creative Commons License so re-use is privileged which aligns it with a foundational tenet of Weller's (2011) definition of OERs. Content is also mapped to the college curriculum, which ensures clinical and contextual relevance (Roland and Brazil 2015).

The RCEM's Strategic Approach and Organisational Culture

The RCEM's involvement with the FOAMed movement reveals the symbiotic but complex relationship between culture and strategy. A core objective of the RCEM is to advance education and research in EM (RCEM 2015) and the organisation's evolving elearning portfolio has tried to advance these two foundational objectives. The aftermath of the RCEM's failed VLE – which was predicated on a commercial model – encouraged the organisation to re-engage with core values and stakeholders to formulate a new strategy, so engagement with cultural values initiated the process (Camillus 2008 cited in Clegg *et al* 2011, p 24) The culture of the speciality primed the organisation to be resourceful in its strategic modelling, and also be receptive to progressive innovations (Ahmed 1998). The remainder of this section will illustrate how the organisation's willingness to evolve its elearning strategy and make a commitment to the FOAMed movement reveals a progressive institutional culture.

Emergency medicine requires its practitioners to be innovative and resourceful (Vartabedian 2014) so it is not surprising that their representative body (i.e. the RCEM's) elearning strategy and approach to OERs does not subscribe to rationalist or classical paradigms (Clegg *et al* 2011). The organisation adheres to Gary Hamel's claim that strategy making must be subversive and willing to critique established practices (cited in Clegg *et al* 2011, pp 20-21). The clinical environments in which members operate are extremely demanding so it is no surprise that the organisation's strategic ethos mirrors this socio-cultural context (Clegg *et al* 2011)

A core tenet of the RCEM's brand is the curriculum, which members of all grades have to demonstrate mastery of. The complexity of this document makes it difficult to imitate and therefore ensures academic advantage is maintained (Johnson *et al* 2004). The curriculum is a core competency

of the organisation, and its continuing development and adaptations to the environmental realities of clinical practice means that it also contributes to building brand awareness (Allen and Seaman 2013). Jones claims that 'strategy is achieved through dialogue and doing' (2004 p 502) and this dialogic and collaborative ethos can also be applied to EM; indeed it helps to explain why the RCEM was so receptive to the FOAMed community. The notion of 'innovatory capacity' (Johnson *et al,* 2004, p 119) also helps illuminate the organisation's appetite to embrace progressive changes in its learning culture. Innovatory capacity is the willingness an organisation has to endorse, experiment and engage with strategic and cultural change (Johnson *et al* 2004). Schein contends that truly innovative cultures have 'environmentally responsive solutions' at their heart (2004, p 130), and the RCFN adheres to this definition.

Schein (2010) claims that deeply embedded and unconscious assumptions are the essence of culture. The view of culture as amorphous but also deeply encoded in institutional beliefs and practices resonates with the interpretation of Martins and Terblanche (2003), and they add that deep-seated beliefs can be expressed in rhetorical cultures and modes of communication, of which FOAMed is one. FOAMed represents a habit of thinking, a mental model or linguistic and rhetorical paradigm which exhibits 'the shared cognitive frames that guide the perceptions, thought and language used by members of the group' (Schein, 2010, p 15). The RCEM's inherently progressive nature is represented by its willingness to diverge from the path followed by AOMRc members, and by the subsequent decision to embrace the FOAMed movement. This innovative and creative ethos helped to form a culture in which new ideas are encouraged, discussion is privileged and innovation is normalised (Martins and Terblanche 2003). Cameron and Quinn (1999 cited in Vijaymumar and Padam 2014, pp. 42-3) developed a taxonomy of dominant cultural types and the most useful one for our purposes is the concept of adhocracy which is characterized by flexibility, risk-taking, a commitment to innovation, tolerance of ambiguity, and success evaluated by the creation of new ideas. The RCEM's organisational

culture therefore replicates the clinical and professional environments of its members, and they are environments that demand resourcefulness and innovation.

Concepts from evolutionary writing also help to illuminate important aspects of innovative and durable cultures (Schein 2010). Resilience is particularly significant, and it is predicated on the work of Holling (1973). Essentially resilience enables change to occur whilst preserving an institution's core identity (Weller and Anderson 2013). Emergency medicine is a highly networked specialty and resilience is evidenced in the diversity within networks or associations (Hall and Winn 2010). Latitude – the maximum amount a system can change before losing its ability to recover – is also significant (Weller and Anderson 2013). The RCEM historically displayed latitude by developing its own VLE rather than going down the e-lfh route; this concomitantly illustrates its appetite for risk as although FOAMed resources are popular they are not yet fully recognized in assessment rubrics and portfolios. A fundamental aim of digital resilience is to retain core functions but allow them to be realized in new forms, and this is evidenced via FOAMed as it can be seen as a critique or meta-commentary of institutionalised knowledge and practices (Hall and Winn 2010)

The emergence of FOAMed has enabled the RCEM to leverage its innate innovatory potential, but it is not without its problems. Specifically these problems relate to how users can reflect upon and prove activity undertaken via FOAMed, and if these resources can be regarded as credible educational activity.

Proposals

There are essentially two strands to the proposals; the RCEM needs to develop a reflective space for individuals to document and reflect upon activity undertaken via the RCFN, and resources produced by the RCFN need to be incorporated into the curriculum. The Open University's 2015 'Innovating Pedagogy' report claims that the 'engine of learning is a continuous cycle of engagement

and reflection' (Sharples *et al* 2015, p 8), so organisations which seek to maintain an innovative status need to ensure they address issues related to both categories.

Learning has to be linked and applied to real world experiences for it to be effective (Kineo 2014). For the RCEM its curriculum is more than an aggregate of clinical competences as it is the roadmap that helps EM physicians navigate through 'real world' challenging environments. FOAMed enables the organisation to stay relevant by regularly updating the curriculum (Ahmed *et al* 2015). All sessions on the RCFN are tagged by curriculum code and a relatively simple thing of adding hyperlinked FOAMed sessions to the bottom of each competency section (see appendix) could go some way to legitimising content.

Reflection is 'an essential aspect of self-regulated and lifelong learning' (Wald *et al,* 2012, p 41). Narrative reflection helps to capture the complexity – and moral ambiguity – inherent in clinical practice; it can also bolster resilience to emotionally challenging situations (Wald *et al* 2012). An element of reflection is currently conducted on Twitter which is beneficial to learners as it enables them to build network capital with other learners and communities of practice (Urry 2007 cited in Hogan 2014, p 7). However networking opportunities afforded by Twitter are not enough, as its brevity encourages rapidity but limits reflective depth. Users can reflect on other platforms but this is an awkward situation; it also detracts from the organisation's innovative capacity as we are not completely linking resources and educational practice to real-world contexts for learners. Roland and Brazil (2015), two of the most recognised figures within EM education, claim that the development of new institutionally-approved reflective spaces is one of the most pressing demands within the speciality's educational discourse.

The proposal here is relatively straightforward as RCEMLearning has an optional reflective narrative section which is displayed to users on completion of every session:

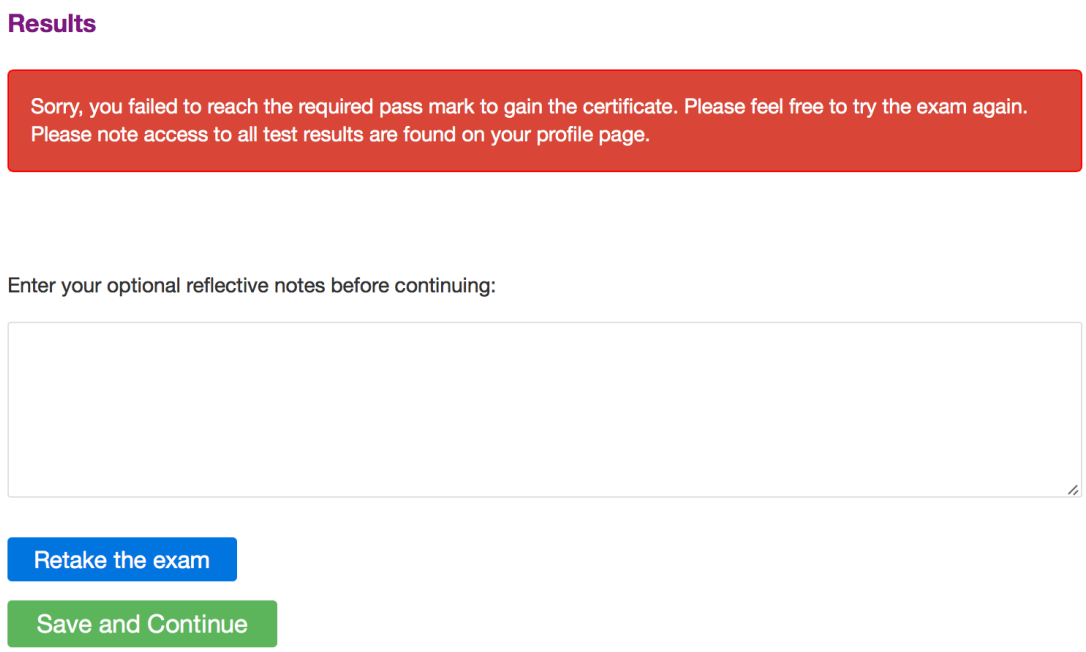

Figure 3: Existing system for reflection in RCEMLearning

The reflective system for the RCFN will be modelled on the above but it will add two domains to ensure it adheres to FOAMed principles, along with demonstrating a commitment to stakeholder engagement:

a) Reflect on the how this will affect your clinical or educational practices
b) The option to contact the team with clinical/educational/technical/general feedback. This will ensure stakeholder engagement channels are transparent.

Developing the functionality to encourage reflective thinking is critical to underpinning the metacognitive potential represented by FOAMed (Roland and Brazil 2015). Successful and sustainable strategies must also be informed by holistic and institution-wide consultation, and the enhanced feedback function will encourage this (Luckin *et al* 2007, Laurillard 2007). This is significant as perspective-gathering helps to crystalize elearning priorities (Luckin *et al* 2007). Ongoing cultural change must also broaden who is regarded as a decision maker and be cognisant of engaging with atypical non-participants, which the feedback function would enable us to do (Nicol and Cohen 2003, Marshall 2010). Storytelling is a core feature of FOAMed but it can also be a feature of change management as it allows an organisation to monitor its emerging narrative as articulated via context-specific stories, which would be delivered via the improved feedback function (Oakland and Tanner

2006). The focus has been on individual reflection here but Marshall (2010) makes the important point that reflective thinking can be improved at an organisational level as well, which underpins the development of this function.

Barriers and Challenges

It is hoped that an institutionally approved reflective space would mitigate the issues surrounding proof of learning undertaken via FOAMed; other concerns remain, especially around data governance. There has been lots of discussion about certifying learning activity conducted on OERs but few suggestions of how to model it (EC Report 2013). There are also sceptical cultural attitudes evidenced in a lack of acceptance from assessing, awarding or employing bodies of activity undertaken on OERs (Allen and Seaman 2013 High Level Group 2014). Although reflective notes demonstrate higher-level engagement it remains to be seen if this will satisfy relevant assessment or awarding bodies.

Use of learning analytics and user data also presents another barrier. Williamson (2015) expresses a cautionary tone about what he refers to as 'data governance,' suggesting that it can often be intrusive and ethically questionable (83). However the RCEM's 'data governance' is under rather than over-developed which implies a missed opportunity at broadening our stakeholder base and developing engagement. Our digital governance needs more attention, as illustrated in the graph below. A disparity has been identified as RCEMLearning commands more site hits but has a much lower session completion rate, where as the RCFN's site hits are significantly inferior yet the podcast downloads are strong. This is a data governance issue as users are going straight to iTunes and not the site, so we are not capitalising on stakeholder engagement:

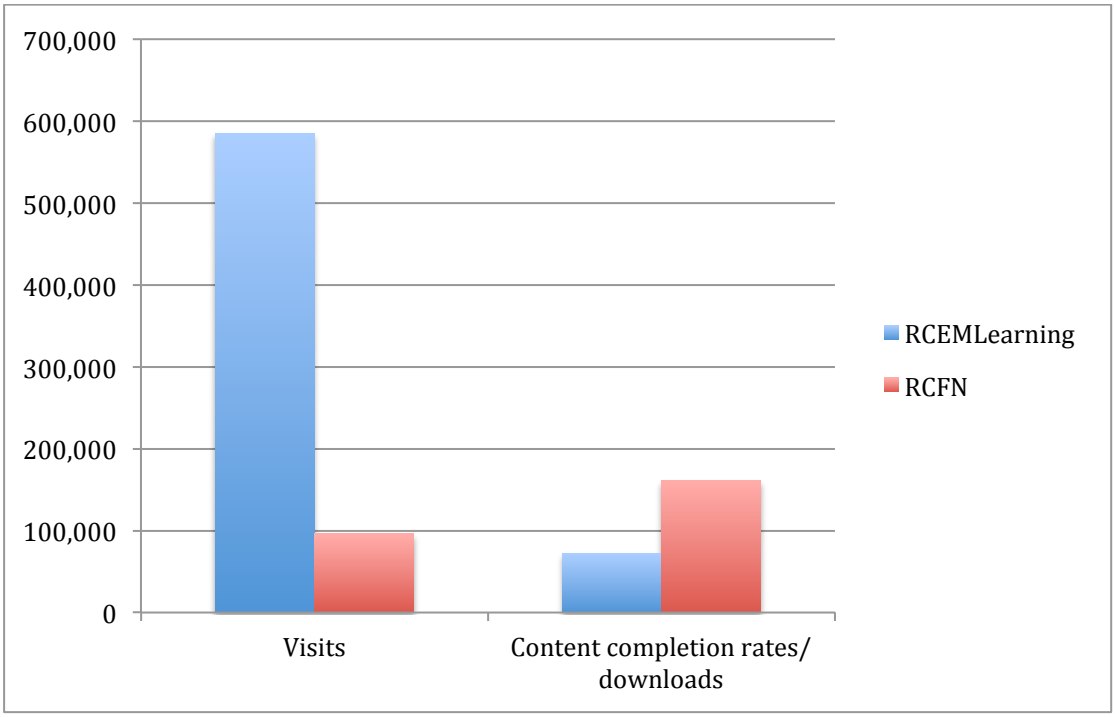

Figure 4: Site traffic and access rates for RCEMLearning and the RCFN[2].

Our current institutional understanding of social learning may also exclude as many as it includes (Williamson 2015). This needs further consideration as we risk normalizing perspectives and undermining FOAMed's oppositional potential. Another ecological metaphor which applies is Weller's notion of panarchy (70). The RCEM is exposed to destabilising external political narratives (Swinford 2016) that have the power to significantly curtail the speciality, so elearning strategy must accommodate this at it translates into increased 'shopfloor' pressures for members. From an internal perspective the college is also suffering from what could be referred to as strategic lag as although the culture promotes innovation via FOAMed senior management are unsure about what tangible outcomes they want to see from it (Ahmed 1998), which could potentially hinder the future development of the RCFN.

Conclusion

With over 160,000 podcast downloads since its launch in September 2014 the RCFN shows no signs of letting up. The organisation has leveraged its innovative capacity to engender a culture where

[2] Data obtained from Google Analytics for the RCFN and the Podalytics app

openness and collaboration is encouraged, and it is one that 'embrace[s] the emergent' (Conner and Clawson, 2004, p 13). Innovative cultures generate their own challenges and the RCFN face three principal ones; developing a suitable reflective space to capture activity; improve feedback channels to ensure stakeholder engagement is maintained; incorporate RCFN resources into the curriculum. It is hoped that the proposals offered here will offset these challenges, and it will be useful to adopt the persona of the *bricoleur* or handyman, which privileges dialogue, communication and heterogeneous perspectives (Clegg *et al* 2011). EM physicians are *bricoleurs* in clinical contexts and their representing body should also look for ways to replicate this within its organisational culture.

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Appendix

CMP3 Major Trauma (including RCFN curriculum-mapped RCFN resources)

To assess the trauma victim using a systematic prioritized approach, be able to resuscitate, identifying life-threatening conditions and stabilize the patient		
Knowledge	**Assessment Methods**	**GMP Domains**
Be able to perform and interpret the primary and secondary survey	E, C, Mi, ACAT, L	1
Undertake emergency airway management including how to perform a cricothyroidotomy and protect the cervical spine	E, C, Mi, ACAT, L	1
Know how to establish IV access including intra-osseous, central venous access and arterial pressure monitoring	E, C, Mi, ACAT, L	1
Be able to identify life-threatening injury especially thoracic and abdominal trauma and know how to undertake needle thoracocentesis and intercostal drain insertion To identify those with aortic injury, diaphragmatic rupture and pulmonary contusion, myocardial contusion, oesophageal rupture, tracheo-bronchial injury, rib and sternal fracture	E, C, Mi, ACAT, L	1
Be able to recognise and manage hypovolaemic shock	E, C, Mi, ACAT, L	1
Understand the uses of peritoneal lavage and FAST scanning	E, C, Mi, ACAT, L	1
Know the principles of management of head injury and the mechanism and effects of raised intracranial pressure, and methods of preventing secondary brain injury	E, C, Mi, ACAT, L	1
Know the principles of anaesthesia in the presence of head injury and major trauma	E, C, Mi, ACAT, L	1
Know the initial management of cervical spine injury	E, C, Mi, ACAT, L	1

Skills		
Be able to assess and immediately manage a trauma patient: perform and interpret primary and secondary survey	Mi, C, S, D, L	1
Provide emergency airway management oxygen therapy and ventilation	Mi, C, S, D, L	1
Be part of the airway team undertaking rapid sequence induction of the injured patient.	Mi, C, S, D, L	1
Be able to provide cervical spine immobilization and log rolling.	Mi, C, S, D, L	1
Assess and manage hypovolaemic shock. Be able to cannulate major vessel for resuscitation and monitoring.	Mi, C, S, D, L	1
Undertake needle thoracocentesis and intercostal drain insertion. Be able to identify and treat tension pneumothorax	Mi, C, S, D, L	1
Be able to assess the patient using the Glasgow Coma Score	Mi, C, S, D, L	1
Undertake initial appropriate investigations e.g. x-match chest x-ray, and be able to interpret them	Mi, C, S, L	1
To provide pain relief for the trauma victim	Mi, C, S, L	1
Be able to undertake safe urinary catheterisation and NG tube insertion	Mi, C, S, D, L	1
Behaviour		
Prompt attendance; focus on resuscitation and life- threatening conditions, good communication and team work	ACAT, C, Mi, L	2, 3
Exhibit a calm methodical approach and be able to prioritise care	ACAT, C, Mi, L	3
Adopt leadership role where appropriate and be able to take over when appropriate	ACAT, C, Mi, L	2,4
Involve senior and specialist services early for those patients with life-or-limb threatening injuries	ACAT, C, Mi, L	2, 3

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RCFN Content for CMP3	Content Type	
Making a difference in Trauma Critical Bleeding	Blog	
Tranexamic Acid in 2015	Blog	
Pee Values	Podcast	
RCEM Manchester Day 3	Podcast	
RCEM Manchester Day 2	Podcast	

The final section (RCFN Content for CMP3) is the proposed addition to each curriculum competency. CMP3 has been selected as it is one of the most tagged competences on the RCFN. Hyperlinking all content tagged to CMP3 legitimises RCFN content as it is embedded into the organisation's most important academic artefact; it also ensures the curriculum represents contemporary clinical practice.