Why webinar CME and why not

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You get an email from your medical school, or perhaps it's a shiny brochure, advertising a continuing medical education (CME) webinar. You can complete another 20–30 activities (hey, they are accredited), which are easy to connect to electronically, either "live" (albeit not in person) or as a stored video. Hmm ... you can now tweet your questions. CME anywhere, anytime, usually at no cost whatsoever. Sometimes you can even Skype in, if at least your top half is dressed. What's not to like?

And yet, again and again, I am happy to pull out my charge card, struggle with northern roads and airlines that don't seem interested in serving me or my luggage, and head to the big smoke, which I publicly dismiss and privately just don't feel very comfortable in anymore.

I am not alone. The Rural and Remote Medicine Course, a premiere event for us rural doctors, keeps getting bigger every year. Other conferences that I register for are also well attended by people who could have stayed at home. Why is e-CME failing to disrupt the traditional CME industry among rural doctors, who should be an easy target?

I truly don't know, but there are several factors at work. On the simplest level, we know that most of the e-content, the talking head, is the least effective form of learning. The most effective learning requires content that is relevant to the participant. It's more visceral than a needs survey; it's the ability of the content provider to respond to your individual practice, and that requires a rich 2-way interaction between the participants and the provider. In the hierarchy of CME, this means the best setting is a small room where the participants learn from themselves and the presenter really acts more as a facilitator.

Then there are the intangibles. Certainly, diversions such as going shopping, going skiing and seeing a show are welcome to hard-working rural doctors and their families. Then there is the networking with people who share similar interests and challenges.

This doesn't mean that e-CME is going to go away, but there's an opportunity to improve its quality. To make remote CME really effective, you need to turn the cameras around, and you have to draw participants into a community of practice. It's not easy to do, never mind do well, but there are examples that work exceptionally well.

One example is Project ECHO (Extension for Community Healthcare Outcomes), which helps rural providers in New Mexico manage the treatment of patients with chronic diseases (http://echo.unm.edu/clinics/clinic-hepc-community.html). It's instructive to consider how this project was built. Its mission was not to provide treatment to patients, but to improve the expertise of rural physicians in providing treatment to patients with chronic diseases, such as hepatitis C, and providing better care without requiring the patients (or doctors) to travel. It's a program that serves to build support for a community of practice.

Remote CME is a fledgling effort, and expanding involves a lot more work than providing the talking head. But rural doctors and their patients are worth that effort.