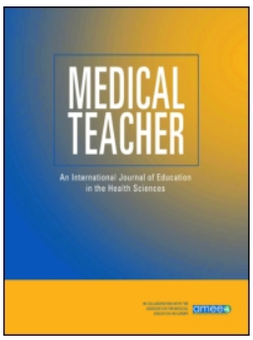

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Presenting a webinar – The need for a standard operating procedure?

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Being invited and doing a webinar for AMEE is a noteworthy experience

Did you know that AMEE organizes webinars? Free of charge and accessible from all around the world? Intended for teachers, trainers, curriculum developers, researchers and anyone with an interest in medical education and 45–60 minutes to spare? We did not, until AMEE invited us to present one. Of course, we were delighted to be invited, but a webinar?

A webinar is a presentation, lecture or workshop transmitted through the internet. Webinars can be either transmitted live with the option to interact or viewed at a more suitable moment without the option to interact with other participants or presenter. With today's available software, it is no longer deemed necessary to have a professional recording studio available. Literally anyone with access to internet and a computer with a built-in or external camera can use video conferencing to give a Webinar. Therefore, webinars are an interesting and cost-attractive way to share knowledge and interact with potentially a very large audience from around the world just at the tip of your fingers. Notably, literature from around the turn of the millennium has already shown that online training can be at least as effective as in-person/classroom-based instruction for cognitive and procedural learning (Schimming 2008).

As intensive care physicians, when preparing interventions or even lectures, the first thing we usually do, is look for the protocol or standard operating procedure (SOP) to not only guide us but also help ensure quality of our work. Unfortunately, despite an extensive literature search, we were unable to come up with a webinar SOP. So, besides sharing our personal views on giving a webinar, we decided to include our plan of attack as well.

The first step, choosing a subject, was not the hardest thing for us, as we both have a special interest in Entrustable Professional Activities (EPAs). To make sure we were up to date on our topic, we performed an extensive literature search prior to preparing our (PowerPoint) presentation. Usually, when giving a lecture, or teaching in general, we know our audience and are able to adapt our teaching to the level of knowledge of the learners. As newbies, or maybe just generally 'older people' in the world of online video conferencing, we were under the impression that we would present for a small and select audience. To our surprise, however, we were told by our liaison at AMEE, that an average AMEE webinar has around 50–100 participants with various backgrounds from all over the world. A whole new world opened up for us. We found anticipating the level of depth required to keep the Webinar interesting to the majority of participants challenging and an extra reason to be not only well-prepared but also expect the unexpected. To try and overcome this great unknown, we decided to add a poll early in the webinar. After introducing ourselves, we would ask our audience:

- Are you: student/resident/medical specialist/NP/PA/educationalist?
- Are you familiar with concept of EPA? yes/no/maybe
- Are EPAs embedded in your training program? yes/no/not sure

As we still expected our audience to be very diverse, ranging from medical students, clinicians to educationalists, and their range of experience to be broad from novice to expert, we decided to use this opportunity to give a bird's eye view of EPAs. We especially wanted to reflect on why and how EPAs were developed and implemented; on supervision and entrustment decisions; on how to build an EPA-based curriculum and conclude with challenges, tips and tricks and cliff-hangers for the future. Getting a general understanding about concept of EPAs as well as enjoying the webinar were our predefined learning goals for our webinar.

Taking the basic rules for a successful PowerPoint presentation into account we developed a 45-minute presentation allowing time to both interact and answer questions at the end and practiced our socks of (Duarte). As we are not native English speakers, we actually practiced our presentation from start to finish several times including availability of internet, the set-up with the camera and laptop. When rehearsing our presentation at work we were so frequently interrupted by our colleagues and phone calls that we decided to reserve a separate conference room for the actual webinar and leave our phones outside.

Then came the day of the webinar. Just before going on air, our AIMEE liaison informed us that no less than 174 participants had registered for the webinar. 174? No pressure at all…! Sitting behind a laptop we started off just a

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little nervous. To our surprise, participants immediately introduced themselves online via the chat box with "hello from the Philippines, from Russia, from Egypt, Dundee (Scotland) and Peru", just to name a few. Surprisingly, even halfway through our introduction the first interesting questions were posed and kept on coming. We decided to stick to our program and save the questions for last. We were vouchsafed with a wonderful opportunity to share knowledge and interact with colleagues interested in EPAs. In the end, to answer as many questions as possible, we got some extra time, but one hour after the start it was time to conclude. A lot of thanks was offered and then our screens and minds went blank.

When debriefing this webinar, as we as intensive care physicians usually do after an intervention, we embraced the things that went well and learned the most from the things that we would do differently the next time. First, this webinar was a great opportunity for us to share and verify our knowledge on EPAs. Published literature gave us the impression that EPAs are not widely being used in Asia and Africa. Our participants from e.g., Singapore, Pakistan and Egypt informed us that this is not the case, they are being developed and implemented in these regions. Secondly, by interacting with interprofessional colleagues from all over the world, we came to realise that EPAs are still a challenging concept and work in progress for both educators and trainees from undergraduate to postgraduate medicine.

Thirdly, although we had time reserved at the end of the presentation to answer questions from participants, we were actually overwhelmed by the amount of questions starting during our introduction and not even two presenters could keep up. We could have easily filled the whole webinar just with responding to these questions. In our next webinar, we will definitely allow for more time for interaction and questions but have additional slides prepared in case interactivity runs low. Finally, not knowing our audience in advance and being able to prepare your presentation to fit the needs of your participants, is something we found challenging but inherent to these kinds of Webinars. You will probably not be able to serve all needs, just make sure that you are able to add extra depth to your presentation when needed.

Would we do another webinar? That would be a resounding yes! Nevertheless, after this noteworthy experience, we feel that a webinar SOP may not be superfluous and are currently working on this.

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Disclosure statement

The authors report no conflict of interest. The authors alone are responsible for the content and writing of the article.

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