CME: *The Bridge to the Wider Practice Community*

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These are interesting times in the continuing medical education (CME) world.

As a new associate dean, I often feel as if I were riding a galloping horse across a rapidly changing landscape—the ride is exhilarating, but I am constantly trying to figure out not only how to get to where I am going, but also where exactly I am trying to go. Deciding on a theme for this editorial posed similar challenges; there is so much going on in CME these days and so much to choose from.

Perhaps we should talk about the future of CME, the evolution from "bums in seats" and "happiness indices" to how we can help clinicians assess and modify their practices. We could develop the theme of CME offices as change agents. Or, then again, perhaps we should talk about the changing scope of CME.

The most obvious change is the broadening of CME to encompass all facets of continuing professional development (CPD). However, depending on the province and on the individual office, CME can also include functions, such as physician assessment, the development and provision of physician remediation programs, various levels of telemedicine and videoconferencing services, small and large research programs, *etc.*

Perhaps we should talk about the role of CME in patient safety initiatives. While the patient safety literature focuses on the in-hospital setting, there is much that can be done in the ambulatory setting that lends itself to CME initiatives.

We could also discuss interprofessional CME. The opportunity for collaboration with other health-care providers and educators is exciting, partly because of the implications for patient safety and improved health-care outcomes.

Perhaps we should talk about the "hot" topic of funding issues in CME. We don't expect or allow outside interests to pay for the bulk of undergraduate or postgraduate medical education—why should CME be different? This leads to the question as to who is responsible for CME—is it the governments, the employers (such as the regional health authorities), the universities, the specialty colleges (CFPC,

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RCPSC) or the individual physicians?

Perhaps we should talk about the role of the CME office in medical school. If we are the specialists in life-long learning, shouldn't we be more involved at the undergraduate and postgraduate levels, sharing our expertise so that, by the time our graduates are out in the "real world," they will have developed good habits that will serve them for a lifetime of practice? Is problem-based learning at the undergraduate (and even at the postgraduate) level transferable to private medical practice or is there a "missing link" that we should be providing?

As is evident from the above, there is no lack of meaningful work or opportunities in the CME field. How do we tie these disparate elements into a cohesive CME strategy? What is the ultimate function of the CME office? We certainly do not have a monopoly on any of the previously mentioned roles; in fact, we sometimes have to explain to others why CME should be involved. Even in our traditional role—that of delivering CME lectures and courses—there are vested interests with budgets that we can only dream of that claim to do at least as good a job as we do. What, then, is the university-based CME's unique contribution—our reason for existing?

I believe that the unique contribution of university CME offices lies in our role as a bridge—a bridge between the university and the wider practice community (particularly those doctors who do not have university appointments); a bridge between the specialty colleges and the faculty (for example, helping departments understand and fulfill the requirements for self-accreditation of rounds and journal clubs); a bridge between the regulatory authorities and practising physicians (by developing and providing CME/CPD that addresses both perceived and unperceived needs and by arranging and providing remediation for physicians in difficulty); a bridge between physicians and the mountain of new medical knowledge (by being a resource to help them access that knowledge, whether by posting available resources on our Web sites, providing courses on how to use new technologies to facilitate point-of-care CME or videoconferencing lectures to distant sites, *etc.*); a bridge between different health-care professions, by working with others to provide inter-professional CME (and modeling inter-professional practice by using an inter-professional team to develop and deliver content) and a bridge between the faculties of medicine and the public (through programs such as "mini-medical school").

As university CME providers, it is easy to feel that we are in the organization, but not truly part of it. Unlike other university departments, we are cost-recovery and we often have to explain to our colleagues exactly what we do (*i.e.*, that we are about much more than just organizing conferences). However, our ultimate goal is identical to that of all who are involved in the health-care system—to ensure the best possible care for our fellow citizens. In university CME offices, we work at this indirectly by supporting physicians in their efforts to provide the best possible care and by being the bridge between the community of practising physicians and the variety of resources they need in order to accomplish this.

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