Roles and Responsibilities of Chief Medical Officers in Member Organizations of the Association of American Medical Colleges
David E. Longnecker, MD, FRCA, Mary Patton, MS, and Robert M. Dickler, MHA

Abstract

Purpose
To explore the roles of physician leaders who hold titles such as chief medical officer (CMO), vice president for medical affairs, and vice dean for clinical affairs in Association of American Medical Colleges (AAMC) member organizations, and to identify critical success factors for these positions.

Method
An Internet-based survey was submitted to 340 physician leaders in 281 AAMC member institutions. The survey posed questions regarding demographics, titles, reporting relationships, time commitments, scope of responsibility, accomplishments, and challenges related to recipients’ positions, among other questions.

Results
Responses were received from 154 physicians representing 139 institutions (response rates 45% and 49%, respectively). Forty-nine percent of these positions had existed for 10 years or less. The most common administrative title was CMO (48%). Eighty-five percent of these individuals reported directly to the dean or CEO of their organization. The majority of administrative effort involved quality and safety (31%), coordination of clinical care (21%), and graduate medical education (9%). The remainder (39%) encompassed a broad portfolio of responsibilities ranging from information technology (6%) to nursing services (2%). Keys to job success included personal stature and relationships, clear definition of responsibilities, and the commitments of the senior administration to the position.

Conclusions
Teaching hospitals and medical schools are creating or strengthening positions for physician leaders, most commonly called CMOs. CMOs’ work involves numerous activities beyond the traditional areas of quality and safety. The effectiveness of these positions requires clear definition of the role throughout the organization and strong, evident support from senior executives in the organization.

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Health care leaders, including deans, their faculty and chief executive officers (CEOs), and their staff, are increasingly challenged to meet the sometimes competing goals of clinical excellence and cost containment in the current health care environment. The expectations for performance are evident in all components of the health care system, including medical schools and teaching hospitals and their associated clinical practices. Indeed, the challenges may be even greater in these organizations because they share additional commitments to research and education that add further complexity to the delivery of patient care. Collectively, these expectations require increasingly sophisticated management approaches to achieve superior outcomes in all realms.

Addressing these challenges requires coordination of clinical care processes at all levels, which has led many administrators of medical schools and teaching hospitals to identify a physician leader who is charged with integrating clinical care into a coordinated system of care delivery. These physicians are identified by a variety of administrative titles that vary from organization to organization but that include titles such as chief medical officer (CMO), vice president for medical affairs, vice dean for clinical affairs, medical director, or chief of staff (especially in Veterans Affairs organizations). (For brevity and convenience only, we will use “CMO” to refer to these various titles subsequently throughout this report, but we emphasize that this is a generic title that encompasses a diverse group of administrative titles that apply to physician leaders.) Informally, many have noted that these positions seem to be more common than they were previously, and the scope of responsibility and authority of these roles seems to have expanded in recent years. We surveyed the holders of these positions in the Association of American Medical Colleges (AAMC) member organizations to gain insight into the roles of CMOs in medical schools and teaching hospitals and to identify further the individual and corporate attributes that will foster effectiveness of these positions. We provide the results of this survey in this report.

Method
We identified the survey pool from AAMC membership files and from queries to deans and CEOs of AAMC member organizations (i.e., medical schools and hospitals or health systems), who we asked to name the physician leader(s) they identified as responsible for clinical care coordination and integration in their organizations. We developed an Internet-based survey using Survey Monkey (www.SurveyMonkey.com, Portland, Ore), a commercial software

Dr. Longnecker is Robert D. Dripps Professor Emeritus of Anesthesiology and Critical Care, University of Pennsylvania, Philadelphia, Pennsylvania, and director, Division of Health Care Affairs, Association of American Medical Colleges, Washington, DC.

Ms. Patton is senior policy analyst, Division of Health Care Affairs, Association of American Medical Colleges, Washington, DC.

Mr. Dickler is senior vice president, Division of Health Care Affairs, Association of American Medical Colleges, Washington, DC.

Correspondence should be addressed to Dr. Longnecker, Association of American Medical Colleges, 2450 N St., NW, Washington, DC 20037; telephone: (202) 862-6113; e-mail: delongnecker@aamc.org.
that is specifically designed and widely used to present questions or assertions in various formats, including multiple-choice questions, questions that require or allow free-text answers, and responses to assertions using a four-point rating scale (i.e., strongly agree, agree, disagree, strongly disagree). Our survey consisted of 37 questions regarding CMOs’ demographic characteristics, titles, duration in and qualification for their positions, reporting relationships, time commitments, scope of responsibility, accomplishments, and challenges related to their positions, as well as factors relating to success and job satisfaction. We informed survey recipients that their individual answers would remain confidential and that only group results would be revealed without their specific consent. The survey was approved by the American Institutes for Human Research consent. The survey was approved by the AAMC. We informed survey recipients that their individual answers would remain confidential and that only group results would be revealed without their specific consent. The survey was approved by the American Institutes for Human Research Institutional Review Board, which provides IRB review services to the AAMC.

We initially sent the survey to 361 individuals, and we sent reminders at monthly intervals to those who had not responded. The survey was open for responses from April through July of 2005. We carefully reviewed the responses to confirm that the respondents were members of the intended recipient pool; 21 respondents were culled from the initial group because they did not meet the criteria for participation (for example, either they were nonphysician administrators or physicians who did not currently perform CMO activities). Thus, the refined recipient list consisted of 340 active CMOs, representing 281 AAMC member institutions.

Depending on the question, responses could be either discrete answers (i.e., selected responses to single or multiple-choice questions, specific numeric information, or selected responses to the four-point rating scale) or free text. Questions dealing with past accomplishments and future challenges were entirely free text, and multiple-choice questions commonly included an option to enter free text (under the heading “Other; please explain”) to enrich the quality of the information provided. We assigned these free-text responses to categories of activity that represented broad areas of administrative or academic effort that are common in health care organizations: education, finance, human relations (internal communications and relations with individuals or discrete entities within the organization), information technology, operations, public affairs (external communications and relations with individuals or entities outside the organization), research, and “other.” The “other” category was reserved for diverse activities that seemed to be unique to a specific individual or organization and thus did not merit a separate category, such as activities associated with the design and building of new hospitals, which did not apply to most CMOs.

We analyzed differences among categoric responses (e.g., category frequencies) by the chi-square test or Fisher exact test (when the sample size for a specific category or class was fewer than five). We used standard mathematical techniques to sum discrete answers and calculate averages.

**Results**

Of the 361 initial recipients of our survey, 175 responded. After we culled the responses of recipients who did not meet participation criteria, we had received confirmed responses from 154 CMOs (response rate = 45%) in 139 U.S. member institutions (response rate = 49%). For clarity, we have summarized the results below under various subheadings. We rounded all values to the nearest whole numbers. Not all respondents answered every question, so the number of respondents is provided for each area.

**Administrative titles**

We asked respondents to identify all their administrative titles, and, when appropriate, to include multiple titles. The most common titles for all 154 responding physicians, in order of frequency, were CMO (48%), vice dean for clinical affairs or similar (37%), vice president for medical affairs or similar (25%), chief of staff (12%), medical director (7%), other (7%), or head of a practice plan (5%).

**Duration of current position**

Forty-nine percent of respondents (76 of 154) reported that their current positions had existed in their organizations for 10 years or less, and 60% indicated that they had occupied their positions for five years or less.

**Qualifications for the position**

 Respondents (n = 153) identified the following as qualifications that led to their selection for the position (respondents were allowed to select multiple criteria): prior practice plan leadership (73%), medical staff leadership (61%), identification as a master clinician (41%), prior hospital administrative experience (29%), holding an advanced degree (in addition to the medical degree) (26%), prior medical school position (19%), or “other” (14%).

Thirty-two percent of respondents (49 of 153) held an advanced degree in addition to the medical degree. The additional degrees held were MBA (13% of respondents), “other” (10%; these often included masters-level degrees in administrative medicine or health care management, MPH (5%), MHA (3%), or PhD (2%).

**Reporting relationships**

We asked respondents to identify all the direct reporting relationships associated with their administrative positions, including multiple reporting lines if present. Eighty-five percent of the 154 who responded reported directly to the dean and/or CEO of their organization.

**Work effort**

We asked respondents to identify the distribution of their total work effort and the distribution of work related specifically to their CMO duties; 149 responded to this question. Overall work effort, in order of decreasing frequency, was distributed among CMO duties (72%), personal clinical practice (13%), other administrative duties (7%), teaching (5%), research (2%), and other (1%). We evaluated the breadth of work effort by determining the percentage of respondents who spent at least some time in various other activities in addition to their CMO duties. Seventy-seven percent of CMOs reported that they participated in some clinical practice. Participation rates in other areas were teaching (64%), other administrative duties (39%), research (20%), and other duties (6%).

Within the subset of CMO duties (72% of total effort), effort was distributed among clinical quality and patient safety (31%), coordination of inpatient and outpatient clinical operations (21%), other (16%), graduate medical education
(GME) (9%), risk management (7%), clinical information systems (6%), public relations (4%), professional liability (4%), and nursing services (2%). As with total work effort, we depicted the breadth of CMO duties by identifying the percentage of CMOs who reported at least some effort in the following activities: clinical quality (91%), patient safety (84%), risk management (76%), GME (70%), inpatient services (67%), outpatient services (65%) clinical information systems (63%), professional liability (61%), public relations (55%), other (48%), and nursing services (26%).

Governance activities

Ninety-three percent of CMOs (119 of 128) reported that they attended their hospital or health system governing board meetings, and 23% were voting members of this body. Seventy-four percent of respondents (95 of 128) indicated their organizations had medical school boards and 53% (50) attended these board meetings; 7% (7) were voting members. Thirty-eight percent of respondents (50 of 134) reported that their medical schools had advisory committees. Of these 50 CMOs, 32% attended the advisory committee meetings and 12% were voting members of the committee.

Past accomplishments and future challenges

We asked respondents to list their three greatest accomplishments during their tenure as CMO and the three greatest challenges they expected over the next three years. One hundred twenty-eight respondents listed 375 accomplishments. The categories of accomplishments, in order of decreasing frequency, were clinical operations (cited by 64% of respondents), human resources (58%), finance (18%), public affairs (17%), legal or regulatory issues (16%), clinical information systems (16%), education (14%), other (13%), and research (10%). One hundred twenty-nine individuals identified 366 future challenges. These challenges, in decreasing order of frequency, were finance (63%), clinical operations (53%), human resources (44%), other (25%), information systems (17%), legal or regulatory issues (11%), education (7%), and research (5%).

We compared the results from the future challenges question to those from the accomplishments question in an effort to estimate whether the focus for CMOs might change in the near future. We observed two significant differences: the category “finance” was cited much more frequently in challenges than in accomplishments (60% versus 18%; \( p = .04 \)), whereas “research” was cited less frequently (5% versus 10%; \( p = .02 \)).

Factors that foster or limit success

We asked respondents to identify the factors that either fostered or limited the effectiveness of the CMO position. The 133 who responded cited the following as the most important factors that fostered their effectiveness: personal history and stature among colleagues (cited by 84%), commitment of the hospital or health system CEO to the goals of the position (78%), and commitment of other hospital or health system administrators to the goals of the position (61%). Numerous other factors were cited also (see Figure 1). Thirty-six percent of respondents (\( n = 129 \)) indicated that no organizational factors limited their effectiveness, but only 63% agreed with the statement, “My job is clearly defined to others in the organization,” and 30% reported that their effectiveness was limited by an unclear definition of the roles and responsibilities of their positions throughout their organizations. Twenty-two percent reported that the clinical department chairs’ lack of commitment to the goals of the position limited the effectiveness of the CMO position (see Figure 2).

Job satisfaction and effectiveness

We asked survey recipients to evaluate their perception of the CMO position in their organizations and their personal job satisfaction in the CMO role, again using a four-point rating scale. Ninety-six percent of CMOs who answered this question (127 of 132) agreed that their efforts had a significant impact on the quality of care in their organizations, and 93% (125 of 134) agreed that they felt satisfied in their current position.

Discussion

These findings provide new insights that enhance our understanding of the CMO position in AAMC member organizations. Further, they provide guidance to those who seek this position and to employers who wish to implement or strengthen this position in their organizations. We have identified three principal findings: (1) CMOs occupy unique roles in their hospitals and medical schools that differ considerably from those of other clinicians or faculty, (2) the work of CMOs is diffuse, involving numerous areas of responsibility that extend well beyond the traditional areas of quality and safety, and (3) the effectiveness of these emerging positions depends not only on the qualities of the individuals who hold them but also on the effectiveness of senior executive leadership (dean and/or CEO) in both supporting and defining the roles and responsibilities of these positions for the CMO as well as for others throughout the organization. A lack of both individual and organizational clarity regarding the roles, responsibilities, and expectations of
the position and lack of support for the position by clinical department chairs, the dean, or other (non-CEO) hospital administrators are major factors that limit success in the CMO position.

The results, of course, are specific to the subset of participants who responded to our survey and may or may not be representative of the entire population of CMOs in teaching hospitals and medical schools. We cannot claim to know the views of all CMOs because not all teaching hospitals are members of the AAMC (and nonmember hospitals did not receive the survey), and we do not know the views of those who received the survey but elected not to respond. However, all respondents were physicians who held current clinical leadership positions in U.S. AAMC member institutions, as documented by questions in the survey, AAMC records, and identification provided by deans or CEOs. Below, we discuss each of the principal findings.

The unique role of the CMO

CMOs spend their time differently than other clinicians in teaching hospitals or other physician faculty in medical schools. Overall, nearly three quarters of CMOs’ time is committed to their administrative role and only 13% is spent in clinical practice (presumably to maintain clinical skills and to experience the challenges of practice firsthand and, thus, maintain or increase their credibility with fellow clinicians). In contrast to other faculty or teaching physicians, CMOs spend only small fractions of their time in research or teaching. Their work activities demonstrate that these individuals are physician executives, not traditional clinicians, physician–scientists, or physician–educators. For many, preparation for the CMO position seems to be evolutionary, following previous leadership roles in the practice plan or medical staff organizations. However, a surprisingly large fraction (32%) of CMOs have prepared for their positions by obtaining advanced degrees in fields that are closely aligned with business (e.g., MBA) or health care (e.g., MPH, MHA or MS in administrative medicine or health care management). Eighty percent (40 of 50) of those CMOs with advanced degrees indicated that the advanced degree was a factor in being appointed to the CMO position. They seem to find value in this additional education, perhaps because it enhances their knowledge and skills, and perhaps because it provides credibility among their administrative colleagues, just as their medical training and experience provide credibility among clinicians.

These other educational experiences may reflect the unusual “bridging” role of the CMO as one who is often a liaison between and among various organizations and groups such as the practice plans, hospitals, and medical schools that comprise academic health systems. Indeed, one CMO recently cautioned others who are considering the role as follows: “Your physician colleagues will believe you have gone to the dark side and your administrative associates will consider you an enigma.”

Although this may be hyperbole, it emphasizes the special role of the CMO as an intermediary between the administrative components of the organization and the clinicians who teach, investigate, and practice in that organization. Because of their experiences as both physicians and administrators, CMOs may offer insights into the unintended consequences of policy and administrative decisions that may not be apparent to those who have not had both experiences. Further, CMOs likely have some advantage when implementing new clinical policies and procedures, because their clinical backgrounds and experiences are recognized by other clinicians in the organization. Management experts have noted that new initiatives are more readily adopted, and with less disruption, if the spokesperson for change has positive relationships with colleagues. Consistent with this observation, CMOs identified relationships and personal stature within the institution as the single most important factor in fostering their success.

Diverse responsibilities

Not surprisingly, CMOs spend a great deal of their work effort on clinical quality, patient safety, and the coordination of inpatient and outpatient services. Perhaps more surprising, their third largest area of administrative time (9%) is devoted to GME. However, this likely reflects the special role of CMOs in AAMC member organizations, all of which are involved in either undergraduate or graduate medical education, or both. The goals of quality and efficiency in clinical care and quality and effectiveness in teaching and learning are central to the missions of AAMC member organizations, and CMOs are often involved in directing, managing, or coordinating these relationships.

The scope of activities that involve the CMO position, as depicted by the percentage of individuals who devoted at least some effort to various areas, demonstrates that these individuals have remarkably diverse “portfolios” of responsibility. The top three areas of administrative work effort (quality and safety, clinical services, and GME) occupy only 61% of CMOs’ time, whereas the

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**Table:**

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<td>Lack of commitment of other hospital/system administrators</td>
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<td>Lack of personal history &amp; stature with colleagues</td>
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**Figure 2:** Factors that limit effectiveness of the CMO position, and percentage of respondents (n = 129) who identified these as factors that limited their effectiveness in the CMO position (respondents could select all factors that applied to their position).
remaining 39% is widely distributed among a variety of activities that encompass a broad array of other responsibilities, including such disparate activities as information systems or nursing services. However, when looking back on their efforts, CMOs identified their most important accomplishments as those involving clinical operations, such as quality and safety initiatives. Typical responses included comments such as “established center of clinical effectiveness and patient safety,” “development of evidence-based practice culture,” “organizational approach to patient safety and clinical excellence with improved outcomes,” and “developed program to detect and understand near misses.” Activities associated with internal communications and relations with physicians (included under “human relations” in this report) were prominent among the listed accomplishments as well. Typical comments included “improved medical staff relations,” “built connections among like disciplines across the network,” and “aligning goals of medical staff and administration.” These comments illustrate the role of the CMO as an intermediary and integrator in the organization.

Financial issues ranked a distant third among CMOs’ past accomplishments, but they are paramount among concerns for the future. Consistent with these observations, 67% of CEOs identified financial concerns as one of their top three “worries” in a 2005 annual survey performed by the American College of Health Care Executives. Thus, it seems that the concerns of CMOs and CEOs are closely aligned as they look to the future. Typical challenges identified by CMOs in our survey included “financial resources to support mission,” “escalating gaps between cost and revenues,” “living within a shrinking budget while patient numbers continue to grow,” or “lack of fiscal resources.” Clinical operations issues and human relations issues ranked closely behind financial concerns, and they continue to challenge these physician leaders.

Fostering effectiveness of the CMO position

Although we do not have data that document the rationale for creating or enhancing these CMO positions in recent years, we speculate that they have grown in response to the recognition that high-quality care comprises a complex matrix of care providers and systems that require institutionally focused oversight and coordination to achieve optimal clinical, educational, and financial outcomes. Recently, a joint effort from the National Academy of Engineering and the Institute of Medicine recommended approaches to transforming the health care system from a group of semiautonomous entities (physicians, physician groups, hospitals, clinics, extended care facilities, nursing services, etc.) into an integrated “high-performance system in which participating units recognize their interdependence and the implications and repercussions of their actions on the system as a whole.” Further, the alignment of entities within academic medical centers has been emphasized as a key component of organizational success, and the evolving CMO role is consistent with that principle. Just as deans often identify key personnel to coordinate large components of the medical school enterprise (e.g., vice dean for research or vice dean for education), both CEOs and deans seem to identify CMOs to coordinate clinical activities. In addition to financial, management, human relations, and leadership skills, an understanding of systems approaches and systems solutions seems to be a valuable attribute for those in the CMO role.

CMOs observed that their effectiveness required not only personal stature and good working relationships, but also strong support for, and commitment to, the position by senior leadership (e.g., CEO, dean, and clinical department chairs) in their organizations. They also identified key factors that limited their effectiveness. Principal among these limiting factors was lack of institutional clarity regarding their role. Only 63% of CMOs agreed with the statement, “My job is clearly defined to others in the organization,” and 30% reported that unclear definition of the CMO role and responsibilities throughout the organization had limited their effectiveness. Perhaps these uncertainties are consistent with the finding that many of these are new or enhanced positions, but certainly this is an area that requires increased attention from top leadership in the organization to foster the effectiveness of these positions. Deans and CEOs should give special consideration to these findings because they represent an area where improved definition, delineation, and communication will result in increased effectiveness of the CMO position.

Perhaps attention to these matters would also help address the second most common factor that limited effectiveness, the lack of commitment of clinical department chairs to the goals of the position. However, this issue may also reflect the inherent tension between autonomy of a department or program and the shared “matrix management” approach that characterizes modern, complex health care organizations, especially as the components are expected to evolve into more closely linked teams that require subordination of individual goals to the overall institutional goal.

In summary, our findings indicate that the U.S. teaching hospitals and medical schools that are members of the AAMC have been creating or enhancing the roles for CMOs (or their equivalents) in recent years, as almost half of these positions have existed for 10 years or less. The activities of CMOs vary considerably by organization and often include activities that are unique to an individual or an organization, but they commonly involve not only quality, safety, and coordination of clinical operations, but also such diverse areas such as GME, risk management, human relations, information systems, public relations, and professional liability. These physician leaders occupy senior positions in their health care organizations and they find their positions to be both meaningful and satisfying. They note that personal stature and support from top-level administrative leaders (i.e., CEO, dean) and clinical departmental chairs are important for their effectiveness, and they report that unclear roles and responsibilities in the organization are the factors that most often limit their effectiveness. The emergence of these positions may reflect the increased focus on quality, safety, and efficiency of clinical operations and the recognition that excellent medical education can only be achieved in an environment of excellent clinical care. The increased stature of the CMO position has led some to speculate that these enhanced positions will foster the development of a cadre of physician–administrators who may well enter the pool of candidates for top executive positions in the future, but
further time and additional research are required to evaluate that hypothesis.

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References

Teaching and Learning Moments

Different Worlds
As medical students annually make the transition from the basic sciences to the clinical years, significant challenges arise. The learning methodology in basic science course work is not greatly different from most undergraduate plans of study. However, the experiential learning that is the essence of clinical science training represents a profoundly different world; this unfamiliar environment of human illness and suffering is vastly more complex than the mundane confines of the classroom.

This different world of intensely personal patient care experiences shapes one’s future attitudes and perspectives. As an introduction to my clinical years, my first assigned patient on my surgical clerkship was a young man just two years older than I was at the time. Suffering from significant abdominal pain and gross hematochezia, he was admitted directly from the state penitentiary where he had been incarcerated for a felony conviction. The colonoscopy revealed a 12-cm fungating mass at the splenic flexure obstructing his large bowel. He had an emergency laparotomy with subtotal colectomy to relieve his impending bowel obstruction. The pathology was positive for mucinous cystic adenocarcinoma and abdominal CT scan revealed widely metastatic disease. As I took care of him with the other members of the general surgery team, I discovered that we both grew up in the same city and went to rival schools. With the support of my parents and friends, I was successful through high school, whereas he, living with only his single, absentee mother, had a horrible home situation and dropped out early to try to make it on the streets. His first transgression with the law was at the age of 17 when he was caught shoplifting at a convenience store. Coincidentally, my first (and hopefully last) transgression with the law also occurred at 17—shoplifting at the college bookstore—and my charges were eventually dropped. The shoplifting charges against him were eventually dropped, too, but he continued to break the law, and when he was 21 years old, he had been convicted for assault with a deadly weapon. By the age of 21, I had successfully graduated from college and entered medical school. Two years later, our life’s paths converged during my surgery rotation.

Through him, I learned a great deal about colostomy wounds, colostomy bags, and skin breakdown. I learned how to put in a central line and how to write for TPN orders. I learned about liver failure, ascites, chronic horrible pain, morphine drips, and palliation. I learned how important it is to really talk with your patient, to try to offer comfort and explain the limits of medical science. I also learned that life is not fair. Despite being raised in the same city, our worlds and our lives were so different. I reflected on the fact that if he had stronger mentors or if my parents would not have been so supportive, our current paths could have been different. Two days before my rotation ended, he fell into a coma and died.

I share this personal story with some of my present clerkship students as an introduction to the different world into which they are now embarking. It also serves as a reminder of the different yet similar worlds our patients share with us.

Jeffrey G. Wong, MD

Dr. Wong is senior associate dean for medical education, Medical University of South Carolina, Charleston, South Carolina.