

## BEYOND THE PHYSICIAN CHARTER

*reflections on medical professionalism*

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**ABSTRACT** The numerous challenges now facing the profession of medicine have led to an intense focus on professionalism by individual physicians and by their professional and academic organizations. In 2002, a distinguished group of leaders in internal medicine created the Physician Charter, which calls on physicians to reaffirm medical professionalism through commitment to three principles and 10 responsibilities. The Charter reflects a duty-based ethic that is chiefly concerned with physician competence. This article offers a critical analysis of the Physician Charter from the perspective of the traditional values of medicine as articulated in medical oaths and championed by leaders of past generations, exemplified by William Osler. The authors argue that medical professionalism should reflect the values of a virtue-based ethic that stresses compassion and beneficence, rather than the values of a duty-based ethic. The challenges that now confront the practice of medicine can be addressed successfully only to the extent that physicians promote virtue-ethics, act collectively in the public interest, and render service that clearly transcends their own self-interests.

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This paper is based in part upon a presentation in May 2003 to a joint meeting of the American Osler Society, the Osler Club of London, and the Japan Osler Society.

*Perspectives in Biology and Medicine*, volume 49, number 2 (spring 2006):263-75

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THE PAST DECADE HAS WITNESSED a major resurgence of interest in medical professionalism, which has become a hot topic in academic centers, professional organizations, and physician offices (Bryan 2003; Pellegrino 2002b; Stevens 2002; Swick 2000, 2001). Factors driving this renewed interest include growing discomfort, alienation, and loss of meaning among physicians who feel besieged by the intrusions of government, business, and other external forces of change; the transformation of medical practice from a professional to a business model (Swick 1998); a perceived erosion of social responsibility at a time when over 44 million Americans (about one in six) are uninsured or lack access to basic health services, and when treatable diseases ravage much of the developing world; and concern within medicine and indeed throughout society about what constitutes a profession and hence the nature of "professionalism."

Traditionally, a profession must meet several criteria, among which are work that is intellectual and involves the application of a specialized body of knowledge; work that is pursued primarily for others and not for oneself; public recognition of the ability to oversee and regulate practice standards; and a commitment to service (Brandeis 1914; Freidson 1988, 2001; Sullivan 1995). There has long been a sense that professional work requires more than simple expertise and cognitive knowledge; there are moral and ethical dimensions as well. In the latter decades of the 20th century, however, all professions, but perhaps none more so than medicine, became identified more and more with technical expertise, and less and less with a sense of service. While exciting and dramatic advances in knowledge have led to new thresholds in physicians' ability to diagnose, treat, and prevent many devastating diseases, they have also posed many new challenges in science, ethics, and public policy. Where should the boundaries be drawn in medical research? When does the application of sophisticated technology impair the quality of life? How can decisions be made about the allocation of limited resources? Who shall receive, and who shall be denied, the benefits of modern medicine?

Professional work has public value and must serve the public's welfare, a concept that William Sullivan (1995, 1999) has called civic professionalism or "the ethic of public responsibility." Physicians have responsibilities not only to individual patients, but to the larger society as well. A renewed emphasis on medical professionalism has been seen as one means to help address the many challenges that confront not only individual patients but also society at large and indeed the global community.

The concern about what comprises a profession and the renewed calls for professionalism are a response to the awareness that the profession of medicine is in crisis and that its very existence as a profession is threatened. Many occupations now press for professional status, in part to control access to a certain type of service and in part for collective status (Kultgen 1988; Larson 1977). But not all occupations have the moral imperative and the ethos of public responsibility that have long characterized medicine and the other "learned" professions.

Not all occupations demand of their adherents the high level of service transcending personal gain that characterizes true professionalism.

### THE PHYSICIAN CHARTER AS A CONSTRUCT OF PROFESSIONALISM

A number of professional and academic organizations have devoted a great deal of attention to the nature of medical professionalism and its importance in contemporary medical practice. The Association of American Medical Colleges, for example, considered professionalism a key outcome in its Medical Schools Objectives Project (Medical School Objectives Writing Group 1999). The Accreditation Council for Graduate Medical Education (2002)—the national accrediting agency for residency training—has adopted professionalism as one of the six core competencies that all residents must demonstrate before they can be considered qualified for independent practice. The American Board of Internal Medicine (2004) requires that physicians document certain attributes of professionalism, such as altruism, compassion, respect, duty, honor, and integrity, in order to gain and maintain their specialty certification.

In late 1999, three major professional societies for internal medicine—two from the United States and one from Europe—launched the Medical Professionalism Project. This collaborative effort gave birth in 2002 to an article entitled “Medical professionalism in the new millennium: a physician charter,” which exhorted physicians to reaffirm the principles of medical professionalism (Medical Professionalism Project 2002). The Charter had its genesis from a concern that “changes in the health care delivery systems in virtually all industrialized countries threaten the very nature and values of medical professionalism” (p. 243).

The Physician Charter identifies three fundamental principles and 10 professional responsibilities that derive from those principles (Table 1). Of the fundamental principles, primacy of patient welfare has been integral to medical oaths since the time of Hippocrates. In identifying the primacy of the patient, the Charter acknowledges the pivotal importance of altruism in creating “the trust that is central to the physician–patient relationship” (American Board of Internal Medicine 2004). The other two fundamental principles, autonomy and social justice, are relative newcomers, aligned with the bioethics movement in the United States during the late 20th century.

The 10 professional responsibilities, viewed as commitments, are prescriptions for physician behavior. A few of the commitments, such as honesty and confidentiality, deal with the relationship between individual physicians and patients; others, such as improving quality of care, deal with the collective responsibilities of the profession; and still others, such as the just distribution of finite resources, address broad societal issues. In that light, the Physician Charter acknowledges the important responsibilities of the profession both to serve individual patients and to discharge Sullivan’s civic professionalism.

**TABLE 1 THE PHYSICIAN CHARTER**

**THREE FUNDAMENTAL PRINCIPLES**

- Primacy of patient welfare
- Patient autonomy
- Social justice

**TEN PROFESSIONAL RESPONSIBILITIES (COMMITMENTS)**

- Commitment to professional competence
- Commitment to honesty with patients
- Commitment to patient confidentiality
- Commitment to maintaining appropriate relations with patients
- Commitment to improving quality of care
- Commitment to improving access to care
- Commitment to a just distribution of finite resources
- Commitment to scientific knowledge
- Commitment to maintaining trust by managing conflicts of interest
- Commitment to professional responsibilities

*Source:* Medical Professionalism Project 2002.

The 10 commitments are implicitly assigned a relative priority through the order in which they are listed in the Physician Charter. Most require no explanation, but the first, commitment to professional competence, merits comment. It is telling that, of all the possible responsibilities of a physician, competence is considered the highest priority. The word *competence* is commonly used and generally understood, but it should be viewed with caution because of its nuances of meaning. As Shakespeare said in *Twelfth Night*, “words are rascals,” and because rascals can be mischievous, it is important occasionally to pause in order to think carefully about the subtle but very real impact of words in common use. *Competence* connotes the ability to do something in a satisfactory, but not outstanding, manner. Physicians must certainly acquire and maintain the vast body of specialized knowledge and the proficiency with technical skills that are demanded in contemporary practice. But in doing so, should they strive to achieve merely a satisfactory performance, or is “competence” too limiting? Should not physicians be committed to the pursuit of excellence in their principal professional activities, whether those be clinical practice or research, teaching or administrative leadership?

The Physician Charter is a pithy, tightly written document, and response to the Charter has thus far been overwhelmingly favorable, as reflected by its endorsement by many medical organizations throughout the world (Blank et al. 2003). These manifold endorsements speak to the importance of the Charter’s stated intent “to encompass a set of principles to which all medical professionals can and should aspire” (Medical Professionalism Project 2002, p. 244). The major criticisms to date largely reflect the Charter’s deontological moorings in the

bioethics movement, with its heavy emphasis on patient autonomy. Several critics aver that the Charter gives insufficient attention to physicians' social roles and responsibilities and to the tenets of a virtue-based ethic (Doukas 2003; Miles 2002; Smith 2005).

In this article, we raise one other concern about the Physician Charter and explore ways in which its important tenets can be augmented by reference to oaths, to older concepts of professionalism as articulated by William Osler, and to behaviors that reflect a covenantal relationship grounded in virtues such as compassion and in long-standing principles and values of professions.

Our concern is that the Physician Charter relies on the language of contracts. The Charter states explicitly in its Preamble that "professionalism is the basis of medicine's contract with society" (Medical Professionalism Project 2002, p. 244). But what does the language of contracts convey about the relationship between physicians and the patients they serve? The word *contract* connotes a formal agreement, especially one that is written and enforceable by law. A contract, then, often implies a relationship of distrust.

The practice of medicine should be based not on distrust, but on trust. Trust has long been a *sine qua non* of the healing encounter, and certainly trust and trustworthiness have long been fundamental to a dyadic healing relationship between patient and physician. Indeed, medicine is to a large extent a moral enterprise precisely because the physician must merit the patient's trust (Pellegrino 1990). Yet in health care today, as Edmund Pellegrino and David Thomasma (1993) have noted, "an ethics of distrust has been gathering force. It would place tighter restraints on professionals or eliminate the need for trust entirely" (p. 65). And a lack of trust leads to an "ethical minimalism," in which physicians limit themselves to the "precise letter of agreement."

The Physician Charter acknowledges that trust is essential, both for the individual patient-physician relationship and to maintain the profession's social contract. When read carefully, however, the contractual language of the Charter has a distinctly legalistic tone. The text of the Charter is laced with such terms as "physicians have a duty to . . ." and "physicians must . . ." and "physicians are required to . . ." Such phrases, written in the third person, imply that physician behavior must be dictated and constrained because physicians cannot be trusted.

### THE PHYSICIAN CHARTER AND MEDICAL OATHS

For centuries, it has fallen to the physician to be the final guarantor of the patient's well-being, and it has been the character of the physician that has formed the basis for the profession's moral and ethical framework. For centuries, these precepts have been symbolized by oaths, which are promises one makes to oneself, to one's profession, and to those one serves. The personal gravity of such promises is reflected by the fact that the language of oaths is almost always in the first person rather than the third person.

The word *profession* comes from the Latin *profiteri*, “to affirm openly,” and its initial usage several centuries ago meant taking the vows of a religious order. In contemporary usage, to claim to be a professional is “to declare openly” certain attitudes, beliefs, knowledge, and skills. In medicine, such avowals and the acceptance of the heavy responsibilities entailed in practice have long been attested by medical oaths. Professionalism, then, can perhaps best be understood when put into the context of oaths.

Medicine is the only profession that still honors an oath, and physicians ascribe to an oath as part of their rites of passage upon entering the profession. In declaring openly their commitments and promises, new physicians join the long line of healers whose mission has long been to prevent disease, to relieve suffering, and to heal the sick. For those entering the profession of medicine, an oath entails much more than the mere recitation of words and phrases. An oath is a solemn promise that makes physicians, *de facto*, a moral community (Pellegrino 1990). An oath sets the profession apart, declaring that those who take it are committed to something beyond self-interest. It reminds both physicians and patients of the profession’s continuity. And an oath has within it a seed of hope against a dispiriting future. “To erase the principles of the medical oath entirely from our consciousness,” Pellegrino (2002a) argues, “would be to make medicine no more than a commercial, industrial or proletarian enterprise” (p. 99). Quite obviously, it would be naïve to think that the many challenges faced by contemporary physicians can be codified in some simple declaration or oath (Pellegrino 1973). An oath cannot insure one’s allegiance to the profession, or serve as an entrée to some promised land, or guarantee the ability of physicians to cope with the profound moral dilemmas that they confront. But oaths can and should establish the moral framework and the healing imperative by which the challenges of medical practice can be more effectively addressed.

The Physician Charter aspires to acquire the weight and bearing of an oath, and hence to take its place in the long tradition of medical oaths dating back over two millennia. Some have suggested that the Charter will take its rightful place alongside the Hippocratic oath and the ethical codes of the American Medical Association (Reiser and Banner 2003; Walsh 2004). A more cynical critic calls the Charter a “very socially conscious, indeed quite ‘politically correct’” document that, unlike the Hippocratic Oath, goes far beyond the boundaries of what individual physicians should or should not do (Johansen 2002). Like Adam (2003), however, we perceive the major difference between the Charter and the Hippocratic Oath to be the contractual nature of the Charter as opposed to the older, more covenantal model for the physician-patient relationship in which most medical oaths are grounded. If a contract connotes a relationship of distrust, a covenant connotes a relationship of trust, even though both reflect a degree of commitment. Social contract theory, as developed historically by Hobbes, Locke, and Rousseau and as recently updated by Rawls (1999) and others, generally refers to limitations that people are willing to place

on their own behaviors in exchange for certain rights and privileges. Contracts require at least two parties, although in the case of a "social contract," mutual consent is largely if not entirely hypothetical. Oaths, on the other hand, are personal commitments that can be made unilaterally. In a covenantal model, the physician's task is not to meet the minimum standards stipulated by a contract but rather to be worthy of trust, not to behave in a certain manner because one is constrained to do so but rather because one feels a genuine commitment to the values of an oath.

In appealing to the covenantal model, we do not wish to minimize the historical ambiguities and limitations of the Hippocratic oath and other older medical oaths, especially as they apply to the 21st century (Edelstein 1967; Miles 2004; Smith 1979). A literal application of the Hippocratic oath—with its appeal to Greek gods and its proscriptions against the use of pessaries—is nonsensical, but an adherence to the principles and values inherent in the Hippocratic oath is still most germane.

One contemporary medical oath concludes: "May I always act so as to preserve the finest traditions of my calling, and may I long experience the joy of healing those who seek my help" (Lasagna 1964). Medical oaths, whatever their origin, should help inspire and preserve the finest traditions of medicine as a healing profession. Statements of medical professionalism, whatever their origin, should not only articulate clearly the principles and values of the profession but also maintain and burnish the long and noble heritage found in the joy of healing.

#### MEDICAL PROFESSIONALISM AND WILLIAM OSLER

It is instructive to consider contemporary constructs of medical professionalism not only from the perspective of medical oaths but also in the context of earlier concepts of professions and professional work.

The concern about medicine as a profession is not new. The Flexner Report of 1910 deplored the large number of medical schools whose poorly trained graduates did not exemplify professionalism. Flexner noted: "The medical profession has become diluted with practitioners of low ideals and professional honor" (p. xiv). These concerns were shared by William Osler (1849–1919), the first Professor of Medicine at the Johns Hopkins University School of Medicine and later Regius Professor of Medicine at Oxford University. Osler was deeply concerned about what he saw as an erosion of professionalism and a loss of idealism in medicine.

Osler's highly successful textbook, *The Principles and Practice of Medicine* (1892), made him the most famous physician in the English-speaking world, but of more lasting importance was his ability to inspire. Even today, Osler is widely acknowledged as an exemplar of medicine's highest values (Bryan 1997). Osler is credited with having had "an unusual facility to make all patients feel that he was interested in them as persons, whether they were on the public wards or on the

private pavilion” (Harrell 1973, p. 553). In the early 1900s, Osler saw, on a single occasion only, the severely retarded son of a poverty-stricken immigrant who had recently arrived from Poland. Nothing could be done to help the child, yet 30 years later, in still-broken English, the boy’s mother recalled of her encounter with Osler: “He looked at me so kindly.” His life and values are exhumed, then, “not primarily out of nostalgia or to create a hero, but . . . to test whether or not his ideas resound through the years, and to decide . . . how best to continue in his spirit” (Banks 2004, p. 31).

The Physician Charter is, to a large extent, a reaction to the growing corporate dominance of physicians and other health care providers. Although this trend is often considered to be a late-20th-century phenomenon (Starr 1982), William Osler, like the authors of the Charter, was concerned about the impact of growing commercialism in medicine. He was deeply worried about the loss of professional values as medicine was being reduced to a trade. In 1903, he told New Haven physicians: “The practice of medicine is not a business and can never be one. . . . Our fellow creatures cannot be dealt with as a man deals in corn and coal; ‘the human heart by which we live’ must control our professional relations” (Osler 1903, p. 333).

In 1907, Osler told London physicians: “You are in this profession as a calling, not as a business, as a calling which exacts from you at every turn self-sacrifice, devotion, love and tenderness to your fellow-men. Once you get down to a purely business level, your influence is gone and the true light of your life is dimmed” (Osler 1907, p. 96). He also stressed to students the importance of empathy: “Nothing will sustain you more potently than the power to recognize in your humdrum routine, as perhaps it may be thought, the true poetry of life—the poetry of the commonplace, of the ordinary man, of the plain, toil-worn woman, with their loves and their joys, their sorrows and their griefs” (Osler 1905, pp. 404–5). He saw medicine arising from a sympathetic desire to help those in sorrow and sickness (Osler 1906).

Supporters of the Physician Charter might argue that its principles and commitments are sufficiently broad to encompass the high ideals articulated by Osler and many others, but the Charter is strangely devoid of such words as *sympathy*, *self-sacrifice*, *devotion*, or *calling*.

The Physician Charter acknowledges physicians’ broader social roles and responsibilities, for which Osler was an advocate. He suggested that physicians had a singular opportunity to improve the lot of humankind: “Linked together by the strong bonds of community of interests, the profession of medicine forms a remarkable world-unit in the progressive evolution of which there is a fuller hope for humanity than in any other direction” (Osler 1906, p. 453). Both Miles (2002) and Stevens (2002) stress that physicians can retain and enhance their professionalism by assuming larger roles in the health of disadvantaged persons, especially in the developing world.



The “fuller hope for humanity” of which Osler spoke can be achieved only by a profession that is more unified than currently, with its balkanization into numerous specialities, subspecialities, and sub-subspecialities. Professionalism is one important means by which medicine can speak with a more unified voice.

### PROFESSIONALISM: IS DUTY ENOUGH?

The Physician Charter is clearly grounded in the bioethics movement, as it developed in the United States during the 1970s and 1980s. Early critics of the bioethics movement focused on its penchant for a rights- or duty-based ethic with emphasis on patient autonomy, rather than on physicians’ traditional values, grounded as they were on a virtue- or character-based ethic (Clements and Sider 1983). The generally accepted principles of the bioethics movement include beneficence and autonomy, but not caring and compassion (Beauchamp and Childress 2001). Beneficence, compassion, and altruism exemplify the higher values of medicine and are grounded in a virtue-based ethic. The Physician Charter pays little if any homage to these values, but instead reflects primarily a duty-based ethic chiefly concerned with physician competence.

*Beneficence*, from the Latin *beneficus*, means “well-doing” or active kindness. Many physicians, including Osler, have been keenly aware that beneficence is the bedrock that distinguishes medicine from other professions. *Compassion*, from the Latin *compati*, literally means “to suffer with,” to actually participate in another’s misfortunes. *Compassion* is often used loosely, in medicine as elsewhere; as the writer Flannery O’Connor (1970) observed, compassion is “a quality which no one can put his finger on in any exact critical sense, so it is always safe for anybody to use” (p. 86). Despite O’Connor’s cautionary note, the quality of compassion is integral to the practice of medicine.

The Physician Charter makes brief mention of “altruism” without discussing what altruism entails. Smith (2005) recently reviewed the Charter and other attempts to capture the meaning of professionalism and concluded: “Although valuable in the debate, these attempts to define professionalism as a set of virtues, obligations, and behaviors fall short of capturing its essence. . . . The core of professionalism is the personal transformation of self that takes place in stages during the early years of medical training and practice” (p. 439).

To understand this apparent dissonance between the duty-based Physician Charter and virtue-based concepts of professionalism, it is helpful view professionalism as a tiered construct with increasing levels of complexity, which for the sake of simplicity might be considered as having two levels: basic and higher (Bryan 2005; Table 2). Basic professionalism—“doing the right thing well”—can be claimed by many fields of work (auto repair, lawn care, house painting). Higher professionalism—“service that clearly transcends self-interest”—is one hallmark of medical professionalism because physicians are called upon to sub-

**TABLE 2** BASIC AND HIGHER PROFESSIONALISM

	<i>Basic professionalism</i>	<i>Higher professionalism</i>
<i>Brief definition</i>	Competent, timely service	Exceptional service that transcends the provider's self-interest
<i>Nature of work</i>	Occupation	Calling
<i>Purpose of work</i>	Often well defined and circumscribed	Often poorly defined and open-ended
<i>Ethical framework</i>	Rights- and duty-based	Virtue-based

Source: Adapted from Bryan 2005.

ordinate their own interests to the interests of their patients, at times at the expense of other activities and interests, and at times even at a real degree of emotional or physical risk.

Basic professionalism involves competent service in exchange for defined reimbursement. Higher professionalism, in contrast, applies to those endeavors that involve a sense of calling and require selflessness in the service of others. The Physician Charter addresses only basic professionalism and is virtually silent about the higher professionalism that is so critical to medicine. It speaks to the duties and competencies of a physician, while the highest measures of professional behaviors lie not in the realm of duty or competence, but in the realm of virtues. Duty alone is not enough.

Over the years, the profession of medicine has made innumerable contributions to the health and well-being of individuals and of communities. It also has offered a proving ground where ethical principles of justice, patients' rights, and moral obligations have been tested. Currently physicians face a new and different sort of challenge: how to preserve, and indeed strengthen, the highest values of medicine at a time when the profession is under siege, threatened with loss of its identity as a profession.

Professionalism can reaffirm medicine's fundamental values and ideals—values and ideals that have been so eloquently expressed by medical oaths and by exemplary physicians like William Osler. These concepts are no mere abstractions. The ideals of medicine are realized, quietly and consciously, every day, in the complex world of medical practice found in physician offices, in outpatient clinics, and at hospital bedsides. Consider, for example, Dr. Carlo Urbani, the 46-year-old Italian physician who, while working at the Vietnam French Hospital in Hanoi, diagnosed what is now called the severe acute respiratory syndrome, or SARS (Reilley et al. 2003). He chose to stay with the local doctors and nurses who quarantined themselves in order to care for patients with SARS, telling his wife "this will be the end of me." Eighteen days later, he died of SARS.

Only the highest standards of medical professionalism, standards that have

withstood the test of time, will be able successfully to carry the profession into the future. Near the end of his life, Osler addressed the Classical Association of Great Britain, during which he spoke of the work of the physician as requiring: "The love of humanity associated with the love of his craft!—philanthropia and philotechnia—the joy of working joined in each one to a true love of his brother" (Osler 1919, p. 31). These ideas were echoed more recently by Goodfield (1973), who wrote: "It may be that until we manage to recover love of the art and love of people, as opposed to love of the technique, or love of the affluence, or love of the status, as the real motivation for entering medicine, we may not get a satisfactory ethical relationship between doctors and society." Medical professionalism must remain an ingredient in the ethically successful practice of medicine in the 21st century (Larkin 2003). The Physician Charter is one important step toward finding a common ground for understanding medical professionalism, but the profession must move beyond the Charter's somewhat narrow focus on duty and competence to embrace the ideals, the genuine sense of selfless service, and the deep commitment to patients that have for so long epitomized the highest values of medicine.

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