Professional Identity Misformation and Burnout: A Call for Graduate Medical Education to Reject "Provider"

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The professionalism of faculty and resident physicians has been on full display during the COVID-19 pandemic. Media stories have notably praised heroic "doctors and nurses" rather than "*providers* and nurses," acknowledging the dedication and training of the people saving lives while putting their own at risk.[1,2] Can this pandemic be the tipping point to finally jettison the depersonalizing, demoralizing, invalidating label "provider"? As a countervailing force against marketplace-driven health care, and in recognition of our duty to solidify the professional identities of physicians-in-training, academic medicine is ideally positioned to discard the term "provider" for the sake of both patients and resident physicians.

In the 1970s, the word "provider" emerged referring to entities such as hospitals, home health agencies, nursing homes, and laboratories,[3–5] but soon shifted to describe physicians, dentists, pharmacists, and transportation providers contracting with Medicare/Medicaid, as in "Medicare providers."[6]

Understanding the power of words, private insurers co-opted "providing" within Medicare by relabeling all physicians as "providers." They concurrently rechristened themselves "health plans," despite offering insurance, not health care. A physician-patient visit became a provider-member encounter, reframing it as a market-based transaction allowed by the insurer. Gradually, faculty physicians and residents have unfortunately adopted this disempowering, insidiously destructive language to describe themselves and their work.

Harms of "Provider"

Rebranding physicians with an economic label has several consequences. First, the word implies that physicians and other health care professionals are interchangeable, rendering a commoditized, untailored service.[7] This tactic is especially inappropriate if done to obfuscate training levels and encourage lower costs to the insurer.[8] Changing a profession to a transposable job succeeds in task-based environments, but not in relationship-based milieus such as medicine or education.[9] Just as with schoolteachers, autonomy is crucial to professionalism[10]; loss of physician autonomy leads to automaticity.[11] Deprofessionalization of physicians therefore harms the public by eroding trust, surrendering individual physicians' clinical judgment to utilitarian cost-cutting algorithms, creating conflicts of interest, and potentially dissuading altruistic, humanistic people from entering medicine.[7,11]

Second, growing numbers of practicing physicians report burnout and feelings of powerlessness in increasingly consolidated, hierarchical health care organizations, which can lead to worse patient care.[12,13] Alarming numbers of residents also experience burnout.[14] Diminishing physicians to "providers," a word otherwise associated with inanimate objects or corporations—utilities provider, internet provider—contributes to all 3 Maslach Burnout Inventory dimensions: emotional exhaustion, lack of personal accomplishment, and depersonalization.[15] Depersonalization, illustrated by statements such as "I feel I deal with my colleagues/patients impersonally, as if they are objects,"[15] may be the most harmful.[16,17] Characterizing human beings as "providers" has a "deliberate sterility to it that wrings out any sense of humanity"[18] and is inherently depersonalizing.

The concept of physician burnout as disenfranchised grief features the continual adaptation to "unacknowledged, cumulative losses"[19] for which grieving would be indicated but not socially sanctioned. Replacing a physician's identity with "provider" causes such grief. Moreover, repeatedly using "provider" sets up for moral injury,[20] in which patients' best interests compete with financial interests of other stakeholders: hospitals, insurers, and employers.

Third, society is awakening to not only overt oppression but also implicit bias and microaggressions of all kinds. Branding physicians as "providers"

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is certainly not a microaggression in the sense of "everyday. . .slights, snubs, or insults, whether intentional or unintentional, which communicate hostile, derogatory, or negative messages to target persons based. . .upon their marginalized group membership,"[21] because physicians have historically been a privileged, not marginalized, group. But downgrading physicians to "provider," while seemingly minor, is cumulatively invalidating; it dishonors physicians' intensive training and weighty responsibility for others' welfare and ignores doctors' inherent role: *docere*, "to teach."

Some misguidedly use the imprecise word to be inclusive of non-physician team members. But our physician assistant and nurse practitioner colleagues did not attend "provider school" either. Attempted inclusivity should not generate unintended devaluation. Precision dictates that we refer to people by their specific roles. If a collective shorthand is desired, members of multidisciplinary teams are better called *clinicians*, which at least acknowledges clinical training, skill, and responsibility.

Fourth, "provider" predominates in primary care and other fields with more women[22] and minorities,[23] as in "primary care providers,"[24] whereas specialists are usually called "-ologist" or "surgeon," appropriately acknowledging their expertise in their medical or surgical disciplines. Consequently, medical students receive the implicit message that primary care specialties are characterized less by expertise and more by their role as a utilitarian cog in the health system wheel. Although uncomfortable to consider, acceptance of "provider" may represent implicit bias within medicine and may disproportionately harm primary care residents as they form professional identities.

Action Steps for Graduate Medical Education Culture Change

It is time to eliminate deprofessionalizing vocabulary. The first step is to get our own house in order. During professional identity formation, we must teach residents the foundational primacy of the physician-patient relationship before wading into the dual agency complicating health care today. In graduate medical education, where supervising physicians have both the opportunity and onus to cultivate and protect the developing professional identities of physicians-in-training, we need to vigorously remind residents and fellows that their hard-earned diplomas proclaim *Doctor of Medicine* or *Doctor of Osteopathic Medicine*, not "Provider." With gentle corrections in conferences and on rounds, residents, fellows, and anyone touching the health care system should recognize "provider" as demeaning, out-of-touch, insensitive, and viscerally discordant with our humanistic values. It should therefore be appropriately stigmatized, much as other fields have eliminated "secretary" and "stewardess."

Authors of undergraduate, graduate, and continuing medical education materials should update all references to physicians with precise, respectful terminology, just as medical schools and residency programs nationwide are revising curricula to reflect values of anti-racism, inclusion, diversity, and equity. Medical journals should, as does the *Journal of Graduate Medical Education*, publish author instructions disallowing "provider."

Individuals can act locally by replying to email or paper correspondence addressing physicians as "providers" with tactful corrections and by requesting that organization leaders expunge this use of the word from all communications and meetings.

Physician administrators in particular should resist corporate language proffered by their business-predominant colleagues. In their interactions with government officials, with the health insurance industry and with health care delivery systems, physician leaders should give respectful feedback about the repetitive injury that "provider" conveys and frame this semantic change as a care quality, business, and physician workforce wellness strategy.

Collectively, medical educators should advocate with government agencies, private insurers, and pharmaceutical companies to retire the label in regulations and legislation and to ask electronic health record vendors to purge the word from their templates. The Association of American Medical Colleges and the American Board of Medical Specialties could develop position statements—such as that of the American Academy of Family Physicians[8]—rejecting "provider" when describing a board-certified physician.

Although no formal survey exists of physician perceptions of the label "provider," prior literature indicates many believe it devalues physicians' intensive training, exacerbates demoralization, or harms the physician-patient relationship.[7,18,24] Physicians who tolerate the term may lack awareness of its insidious negative effects.

In creating their life's aspirations, none of our residents or students declared, "I want to be a provider." Calling them *physicians* may help residents recognize that their deeply meaningful interactions with patients signify so much more than a series of economic transactions. Starting in the imprinting setting of graduate medical education, it is time to resist deprofessionalization burnout, serve patients' interests, and safeguard young physicians' professional

identity formation. Let us train residents not as "providers," but as physicians.

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