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POSITION PAPER

Physicians Are Not Providers: The Ethical Significance of Names in Health Care: A Policy Paper From the American College of Physicians

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More than 25 years ago, Pellegrino and Relman noted the increasing commercialization of the learned professions, anticipating what many physicians are increasingly experiencing today: an impairment of their ability to practice in accordance with standards of medical ethics and professionalism. These hurdles to the physician's ability to do right by the patient contribute to what leaders in medicine and the American College of Physicians have called deprofessionalization. An example is the use of the term *provider* to describe physicians and other health professionals. The use of this terminology has been reviewed in medical journal articles but has not been adequately explored as a matter of ethics and professionalism. Through that lens, this paper examines the trends, significance, and implications for patients, physicians, and health care of the use of the term *provider*.

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What's in a name? That which we call a rose
By any other name would smell as sweet. . .
—William Shakespeare, *Romeo and Juliet* (1)

With apologies to Shakespeare, names are important. In health care, they can have ethical significance.

The American College of Physicians (ACP) is concerned about the use of the term *provider* to describe physicians. Medical journal articles have criticized the term as deemphasizing professional identity, with particular negative ramifications for primary care because differences in training and expertise among clinicians are not recognized; others have found it to be ambiguous and disrespectful (2–5). Yet the use of *provider* has not been adequately examined as an ethical matter.

The word *provider* represents one of many challenges to ethics and professionalism posed by corporatization, commercialization, and physician employment, among other aspects of today's practice environment (6–8). The issues are not new. From Galen to Paracelsus to Sir William Osler, distinguishing the patient–physician relationship from commercial transactions has been critical. As Osler said, "The practice of medicine is an art, not a trade; a calling, not a business. . ." (9).

It is also essential to consider the use of the term *provider* given changes in health care delivery over time. Changing societal and cultural expectations are embedded in physicians' roles and the context of care, such as challenges posed by electronic health records and technological advances. Civil rights and consumer movements (8) have stimulated greater patient engagement, especially in medical decision making, and led to increased self-management by patients.

In 1980, Relman described the rise of the "medical-industrial complex" (10); in 1999, Pellegrino and Relman examined the increasing commercialization of the learned professions (11). They anticipated what many clinicians experience today: deprofessionalization, an impairment of the ability to practice according to the precepts of ethics and professionalism (7, 11). Has language helped cause these shifts, is language a result of them, or are both true? This paper examines trends and implications for patients, physicians, and health care of the term *provider* from the perspective of medical ethics and professionalism.

Methods

This paper was developed on behalf of the ACP Ethics, Professionalism and Human Rights Committee (EPHRC). Committee members abide by the ACP's conflict-of-interest policy and procedures; appointment to the EPHRC and its procedures are governed by the ACP's bylaws. Following environmental assessment to determine the scope of issues and literature reviews, the EPHRC evaluated and discussed drafts of the paper; it was then reviewed by the ACP Board of Governors, Board of Regents, Council of Early Career Physicians, Council of Resident/Fellow Members, Council of Student Members, and other committees and experts and was revised to incorporate comments

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Origins of Words Associated With Care

Paydarfar and Schwartz trace the origin of the use of the word *provider* to Medicare and Medicaid law (1965), which refers to "any provider of services" (2). They found it to be a "peculiar descriptor" when applied to physicians given its common use to describe suppliers delivering products and services to markets. Goroll describes the use of *provider* for hospitals or networks referring to institutions or insurers (3) but not for human-to-human relationships and interactions. Use of *provider* before the 1960s has been historically contested (12), but the term has clearly evolved to encompass diverse types of clinicians.

Medical care is not a mere service. This is especially apparent in the origins of words associated with care. The *Oxford English Dictionary* defines the origins of the terms *patient*, *physician*, and *medicine*. *Patient* is from the Latin *patiens*, for one who suffers. This word refers to the vulnerability often brought on by illness. *Doctor* comes from the Latin *docere* ("to teach"). *Physick* originally meant medical treatment or remedy; one who practiced physick was a physician. By the 18th century, *physic* referred to the practice of medicine. *Compassion* comes from the Latin *compassio*, meaning "to suffer with." Compassion is essential to the patient–physician relationship; it is not just empathy or kindness but refers to supporting the patient in need and acting with and for the patient. These words help convey the significance of what is at stake in medical care.

The Implications of Language for Care and for Ethics and Professionalism

Language has myriad implications for health care as well as for ethics and professionalism. First, the current use of *provider* in reference to institutions, insurers, physicians, nurses, physician assistants, and other clinicians lumps impersonal entities in with humans and obscures differences in clinical training and expertise (3). For patients, who need to be aware of the important and different roles of health care team members, such distinctions may not be transparent.

Second, the duties of physicians differ from those of individuals and entities who deliver commercial and other services. The physician's ethical responsibilities are primary when delivering patient care—arising from the patient's experience of illness—and inform the nature of medical decisions in the context of diagnosing and treating illness and preventing disease (13). The patient–physician interaction focuses on maintaining or improving the health of the patient. This partnership is not transactional but rather relational, with the patient seeking care from a physician who is trained to help and bound by ethical duties to do so.

Patients are not mere consumers; they have dignity and individual needs. The physician must act in the patient's best interests (the ethical principle of beneficence, promoting the good of the patient), even when it is counter to the physician's own interests or conflicts. The physician must avoid doing harm (the duty of nonmaleficence), such as unnecessary tests and procedures; respect patient autonomy; and consider issues of justice, such as equity and the responsible stewardship of resources (8).

Third, use of the term *provider* undermines ethics and professionalism. Medicine is dedicated to serving others whose trust must be earned. As quoted in the *ACP Ethics Manual*, Francis Peabody said that medicine is not "a trade to be learned, but a profession to be entered" (8), with publicly declared values (in Latin, the "profess" in "profession") and ethical duties to uphold. The professional prerogatives and rights that society grants to physicians include expectations that physicians will use their role to benefit patients. Physicians are accountable to the public for their professional actions (8). The mission of hospitals was once aligned with and supported the ethical duties of physicians to serve the needs of patients first and to avoid commercialism (14), but that role has often been compromised. Admittedly, professionalism and commerce coexist in medicine to advance clinical practice and research; it becomes problematic when underlying motivations are economic and not ethical (14). Today, commerce and professionalism are imbalanced, with the forces of commercialism growing (7).

The term *profession* is often used loosely. But medicine is a *learned* profession, of which there are only a few (15); it requires "educational breadth," dedication to service, and putting patient care above self-interest to fulfill a "fundamental human need." Altruism and the desire to help people need to be fundamental motivators in this ethical endeavor that is committed to the welfare of patients (15).

A physician should be a trusted confidant, counselor, advocate, and partner in times of need. Since Hippocrates, physicians have committed to putting the interests of patients first, utilizing their extensive knowledge, training, and experience to benefit patients and help keep them from harm. In contrast, providers provide. Business transactions need not focus on values or consider the interests of consumers before those of stockholders and owners.

Fourth, language not only affects the perception and value attributed to what is being provided but can also alter one's professional sense of self and influence behavior (2, 16). Communication and language are key. To quote Robert M. McLean, MD, former president of ACP, "Patients share things with us that they share with nobody else, including close family" (17). Language should focus on "health and not healthcare, on relationships and not transactions, and on people and not products" (18). Terms such as "covered lives," patient

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"leakage," and others that focus on the "healthcare industry" undermine the physician's role and should be avoided. *Health care* should be 2 words: *health* (including the opportunity for its fulfillment for all [19]) and care (attending to patients).

Recommendation

Language in health care has ethical and practical implications. Physicians should be referred to as physicians*, not* providers*. Also, when describing professionals with varied credentials who care for patients, the terms* clinicians *or* health care professionals*, not* providers*, should be used.*

Conclusion

ACP supports transformative changes to promote quality and access to health care. This objective needs to uphold the ethics of the patient–physician relationship, which is fundamental to the practice of medicine. The words *physician* and *provider* are not interchangeable. *Provider* undermines the physician's ethical obligations, clinical integrity, and accountability, as well as trust in the patient–physician relationship. The term should not be used to describe physicians, nor should physicians use it to describe themselves, their team members, or their trainees.

Patients still want trusted, compassionate relationships and care by humanistic physicians who exercise independent clinical judgment and profess to heal when possible and to comfort always. Physicians should strive to fulfill these expectations, and language should recognize and support their individual and collective ethical responsibilities to serve patients.

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References

1. **Shakespeare W**. Romeo and Juliet. Act 2, scene 2, lines 43-44. Dover Publications; 2014.
2. **Paydarfar D, Schwartz WJ.** A piece of my mind. Dear provider. JAMA. 2011;305:2046-2047. [PMID: 21610229] doi:10.1001/jama.2011.702
3. **Goroll AH.** Eliminating the term primary care "provider": consequences of language for the future of primary care. JAMA. 2016; 315:1833-1834. [PMID: 27031172] doi:10.1001/jama.2016.2329
4. **Mangione S, Mandell BF, Post SG.** The language game: we are physicians, not providers. Am J Med. 2021;134:1444-1446. [PMID: 34297975] doi:10.1016/j.amjmed.2021.06.031
5. **Beasley JW, Roberts RG, Goroll AH.** Promoting trust and morale by changing how the word *provider* is used: encouraging specificity and transparency. JAMA. 2021;325:2343-2344. [PMID: 34047757] doi:10.1001/jama.2021.6046
6. **Leffler C, Snyder L; American College of Physicians**. Medical professionalism in the changing health care environment: revitalizing internal medicine by focusing on the patient–physician relationship. American College of Physicians; 2005.
7. **DeCamp M, Snyder Sulmasy L; American College of Physicians Ethics, Professionalism and Human Rights Committee.** Ethical and professionalism implications of physician employment and health care business practices: a policy paper from the American College of Physicians. Ann Intern Med. 2021;174:844-851. [PMID: 33721520] doi:10.7326/M20-7093
8. **Sulmasy LS, Bledsoe TA; ACP Ethics, Professionalism and Human Rights Committee.** American College of Physicians ethics manual: seventh edition. Ann Intern Med. 2019;170:S1-S32. [PMID: 30641552] doi:10.7326/M18-2160
9. **Osler W**. Aequanimitas: With Other Addresses to Medical Students, Nurses and Practitioners of Medicine. P. Blakiston's Son & Co; 1904.
10. **Relman AS.** The new medical-industrial complex. N Engl J Med. 1980;303:963-970. [PMID: 7412851] doi:10.1056/NEJM198010233031703
11. **Pellegrino ED, Relman AS.** Professional medical associations: ethical and practical guidelines. JAMA. 1999;282:984-986. [PMID: 10485685] doi:10.1001/jama.282.10.984
12. **Raz M, Freedman D, Roelcke V.** Physicians or "providers?" Inventing Nazi origins undermines debates on medical professionalism. J Gen Intern Med. 2022;37:3479-3481. [PMID: 35882707] doi:10.1007/s11606-022-07725-9
13. **Pellegrino ED.** Toward a reconstruction of medical morality. Am J Bioeth. 2006;6:65-71. doi:10.1080/15265160500508601 [16500860]
14. **Fins JJ.** Commercialism in the clinic: finding balance in medical professionalism. Camb Q Healthc Ethics. 2007;16:425. [PMID: 18018923] doi:10.1017/s0963180107070533
15. **Pellegrino ED.** Professionalism, profession and the virtues of the good physician. Mt Sinai J Med. 2002;69:378-384. [PMID: 12429956]
16. **Lehmann LS, Sulmasy LS, Desai S; ACP Ethics, Professionalism and Human Rights Committee.** Hidden curricula, ethics, and professionalism: optimizing clinical learning environments in becoming and being a physician: a position paper of the American College of Physicians. Ann Intern Med. 2018;168:506-508. [PMID: 29482210] doi:10.7326/M17-2058
17. **McLean RM**. Defining our identity does not include the 'P word.' I.M. Matters from ACP. September 2019.
18. **Park AL, Aronson L, Diab M.** To provide care, or to care for? The influence of language on medicine. J Bone Joint Surg Am. 2025;107:520-522. [PMID: 39418347] doi:10.2106/JBJS.23.01051
19. **DeCamp M, Snyder Sulmasy L; ACP Ethics, Professionalism and Human Rights Committee.** Health as a human right: a position paper from the American College of Physicians. Ann Intern Med. 2023;176:1516-1519. [PMID: 37903364] doi:10.7326/M23-1900

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