

EDITORIALS

More Than a Provider: Reclaiming the Language of Relationship in Medicine

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The American College of Physicians recently issued guidance discouraging the use of the term “provider” when referring to physicians. At first glance, this may appear semantic—an exercise in professional preference rather than substance. It’s not. Language shapes identity, and identity shapes behavior. In medicine, both shape patient experience and, ultimately, quality and outcomes.

This concern is not exclusive to physicians. It extends equally to nurse practitioners, physician assistants, and all clinicians engaged in patient care. The issue is not hierarchy, it is orientation. When we default to “provider,” we risk flattening distinctions not of status, but of professional identity grounded in responsibility, continuity, and trust.

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“Provider” is a term born from systems—billing/credentialing frameworks, administrative standardization, and the need to categorize roles across a fragmented healthcare landscape. It is a term that reflects a transactional relationship. It is efficient and scalable, but it is also reductive.

Prioritizing the doctor-patient relationship

For many of us, the call to medicine was never transactional. It was relational. I grew up hearing stories from my uncle, a general surgeon, and my two cousins during their medical school training. The stories not of procedures or diagnoses alone, but of relationships with patients known over time; patients

whose lives intersected with theirs in meaningful, sometimes profound ways. The work was not merely to “provide” care, but to own outcomes, steward decisions, and accompany patients through uncertainty.

That framing matters, especially now, in the world of the digitalization of medicine. Young physicians entering practice today face the realities of balancing documentation versus dialogue, efficiency versus depth. In the complex clinical environment, language becomes a quiet but powerful signal. If we accept “provider” uncritically, we risk internalizing a narrower version of our role, one that aligns more with task completion than with the prioritization of personalized care and the unique responsibility that is the doctor-patient relationship.

I say this while being part of a large organization myself; an independent, multispecialty medical group with over 450 physicians and advanced practice clinicians (APC’s), and over 2,500 team members. When I reflect on many of our meetings and discussions, what I hear most often is not the language of transactions, but rather how to improve care and access, provide support, bring new treatments forward, engage patients more effectively, and take care of the whole person as a team.

Reclaiming more precise language—physician, clinician, nurse practitioner, physician assistant—is not about nostalgia or elitism. It is about preserving the conceptual model of care as a partnership with the patient aimed at preventing, managing, and treating both acute medical conditions and improving long term health. It reinforces a sense of ownership for clinicians and it fosters trust for patients.

Patients rarely perceive their care as a series of discrete transactions. They are not customers or clients in the ordinary sense, and I am not merely a provider of healthcare transactions to them. They remember who listened, who followed up, and who helped guide them with coordinated care throughout their journey in this ever-complex healthcare system. They remember the continuity of the clinician’s presence over time. That memory forms the basis of trust, and trust is the foundation of effective care.

We are not providers. The distinction is subtle. The implications are not. We proudly prioritize these relationships, which are unique and deeply human.

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