Respect is a cornerstone of professionalism in medicine. The language we use is a critical medium through which respect is conveyed to colleagues and patients. Conversely, inappropriate language can also communicate lack of respect. Changing language to promote respect also promotes professionalism. In short, language matters to upholding the fundamental principles of medicine.

Olson et al describe an intervention targeted at role misidentification, a common problem faced by women and underrepresented in medicine physicians, in which they are assumed to not be a physician by other health professionals or patients. Role misidentification can reflect implicit or even explicit bias and contributes to negative learning and working environments. Role misidentification is closely related to untitleing and uncredentialing, described recently by Diehl and Dzubinski. These are common forms of workplace bias that disproportionately affect underrepresented individuals, women, and especially those challenged by the intersectionality of gender, race, ethnicity, religion, or sexual orientation. For example, women are less likely to be introduced at medical conferences by their professional title. Even when the intention is not malicious, role misidentification, untitleing, and uncredentialing demonstrate a lack of respect for health care professionals and are far too prevalent. At baseline in the study of Olsen et al, nearly two-thirds of women residents reported experiencing gender bias and one-third reported role misidentification by other physicians, 58% by other health care team members, and 82% by patients, with similar numbers for underrepresented in medicine residents. Importantly, frequencies among residents who were men were markedly lower.

The intervention in the study of Olsen et al was simple—adding the identifier “DOCTOR” to identification badges worn by residents in 6 different specialties. After 8 weeks with the updated identification badges, the frequency of misidentification was dramatically reduced for all resident groups and from all sources of misidentification. These results are striking, but several additional observations from this study merit discussion.

First, patient comments favored the badges for the role clarity they offered. Medical teams are often large and multidisciplinary, and it can be difficult for patients and families to know who is functioning in specific roles. Making these roles more evident is a service to patients. Second, participants suggested that clear identification should be worn by all physicians, not just marginalized groups. In fact, clear rolespecific identification should be in place for all care team members to normalize role recognition and transparency. Third, medicine is afflicted with an insidious form of gaslighting within its ranks whereby the untitled are disparaged as entitled when they request the basic respect of proper role identification. In the study of Olson et al, this was most apparent in surgical disciplines, but this experience will resonate with physicians across fields.

With particular impact on marginalized groups, the issues of untitleing and uncredentialing extend to another misuse of language affecting medical professionals—the increasingly pervasive use of the generic term provider within the medical lexicon. Use of this word in medical contexts derives from insurance and legislative language related to the industrialization and commoditization of medicine in the 1960s and is discordant with the core values of medicine. Indeed, “provider status” indicates...
ability to generate services billable to or covered by Medicare, and, for example, under Health Insurance Portability and Accountability Act legislation, “health care provider” includes “any other person or organization who furnishes, bills, or is paid for health care in the normal course of business.” As such, this term is directly connected to the encroachment of business interests into the relationship between patients and health care professionals.

Notably, provider has never been an occupation or job title in medicine, so it is inaccurate and improper to use this word to describe individual health care professionals in their work roles. This applies to physicians, physician assistants, nurse practitioners, nurses, and every other group of professionals on the health care team. For some individuals, other language adds further degrees of disrespect, such as “mid-level provider” or “advanced practice provider.” Nonetheless, provider has crept into our parlance steadily over the years, especially because it is a preferred term in some electronic medical record systems, even though it does not serve medicine well. This term is problematic for many health professionals, who find it “devoid of any reference to their professionalism, level of training, or unique contribution to care” of patients. This ambiguous term is imprecise and confusing, does not engender trust in the patient-clinician relationship, and is contrary to the professional identity formation critical in the health professions. It is diminishing and “inherently depersonalizing,” and as such contributes to burnout, moral injury, and other forms of distress. Perhaps most important, it is a systematic untitling and uncredentialing term that communicates lack of respect for the individual, their training, and their expertise.

It is noteworthy that numerous medical organizations including the American Medical Association, American College of Physicians, and American Academy of Family Physicians have official policies against use of this term to reference individuals, and some medical journals, such as the *Journal of Graduate Medical Education*, do not allow this term to be used to describe any health care professionals. This attests to the fact that alternatives exist (as they did before the 1960s). For example, in referencing groups containing multiple medical job roles, *clinicians* and *health care professionals* are terms without the negative history and connotations of provider.

Finally, language in medicine must also demonstrate respect for patients as individuals. Guidance for inclusive language is offered in the *AMA Manual of Style*. Key themes include recommendations to be specific, to avoid stigmatizing words, and to center on the person, all well aligned with the discussion of respectful language for health care professionals.

Role misidentification, untitling, and uncredentialing, including use of the term *provider*, dishonor our commitment to respect as a cornerstone of medical professionalism. Language in medicine should be grounded in person-centered respect. To further this goal, we make several recommendations:

1. Medical organizations and professionals should prioritize use of individual descriptors and titles that precisely capture credentials and job roles. This will reduce confusion and promote trust and transparency for patients and health care professionals across job categories.
2. In referring to groups including multiple categories of health care professionals, terms without the negative connotations of provider should be used if individual job roles cannot be referenced. Examples include clinician, health professional, and health care professional.
3. Similarly problematic terms, such as mid-level, affecting key members of the health care team should be removed from usage to demonstrate mutual respect and to provide clarity in job roles.
4. Language used to describe patients and their life experiences should be oriented to the person and demonstrate respect.

By implementing these proposals, health care organizations, medical societies,
academic journals, and individual health care professionals can demonstrate their commitment to respect as a foundation of professionalism in medicine. Our colleagues and our patients deserve this consideration.

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