VIEWPOINT

Eliminating the Term Primary Care "Provider"
Consequences of Language for the Future of Primary Care

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The term "provider" first appeared in the modern health care lexicon as a shorthand referring to delivery entities such as group practices, hospitals, and networks. More recently, its use has expanded to encompass physicians, nurse practitioners (NPs), physician assistants (PAs), and perhaps others, especially those engaged in delivery of primary care.[1] On one level, this expansion is both logical and convenient, as it reflects the importance of a multidisciplinary approach to modern primary care delivery, extending beyond the traditional dyad of patient and physician.[2-4] Being designated as a "primary care provider" also denotes qualifying for payment of services rendered,[1] a designation long sought and highly valued by advanced-practice nurses and PAs.[3] Although useful in these contexts, the term "provider" has the potential for adverse consequences for primary care, calling into question the wisdom of its expanded use.

From the patient's perspective, getting to the right primary care team member becomes problematic if all practitioners are indistinguishably designated as "providers," which implies they are interchangeable. The term obscures their differences in depth and breadth of training, knowledge, and clinical experience as well as the particular and often unique contributions they make to a team-based effort. In well-structured, high-performance primary care practices such as the patient-centered medical home,[4] care is taken to define and communicate the roles and responsibilities of team members according to their specific competencies.

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Nonetheless, in busy daily practice, ensuring a proper match of the patient's problem and needs with a team member's specific competencies can be challenging and impeded if all members of the clinical practice team are similarly labeled. Inappropriate triage to a mismatched "provider" risks both underresponses and overresponses, such as missing an early manifestation of serious illness or prematurely ordering high-cost tests and specialty referrals—patient safety and cost-effectiveness may be adversely affected. For some patients, the resultant uncertainty and insecurity about who is going to handle their medical problem leads those with financial means to sign up for "concierge" or "direct care" arrangements, often paying handsomely for guaranteed direct physician access.

Similarly, for primary care team members, the undifferentiated designation of "primary care provider" has the potential to put some into situations beyond their level of training and clinical competence. This is particularly important with respect to initial diagnosis and differential diagnosis, critical responsibilities of front-line primary care. Two factors make these tasks especially challenging in the primary care setting: the broad spectrum of problems encountered and the poorly differentiated nature of many presenting complaints. To deal with these factors effectively from the outset requires considerable clinical acumen and training, including an extensive in-depth knowledge of pathophysiology, disease presentations, and test selection and interpretation. These elements constitute a substantial part of the many years of physician basic science and clinical training and distinguish it from that of other health care professionals.

The ability to correctly diagnose and act accordingly in a timely and appropriate fashion is essential to patient safety and often the difference between a favorable and unfavorable outcome.[5] In well-functioning primary care teams, indications for prompt hand-off to the proper team member are clearly specified; however, use of the designation "provider" blunts this role differentiation and can foster role confusion, with adverse consequences for both patient and team member. The same pertains to making initial treatment decisions. Use of information technology to deliver protocols and other decision support tools can help mitigate some of the front-line diagnostic and management challenges for team members facing situations beyond their level of expertise, but these are no substitute for proper teamwork and timely physician involvement.

Assigning the "provider" designation to primary care health professionals also risks deprofessionalizing them. MDs, NPs, PAs, RNs, and LPNs value their specific professional identities, proud to be referred to as such and respected for the professional values they connote, which include an overarching commitment to the patient's welfare, high standards of care, and continuous learning and quality improvement. The term "provider" makes no reference to professional values or professionalism; its use

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can lead to the inference that such values do not matter, potentially fostering an unprofessional work environment.

Using the "provider" designation in primary care also suggests that primary care is simple care that can be commoditized and delivered piecemeal in a variety of settings by less well-trained personnel operating interchangeably at low cost. As such, use of the term may promote low levels of compensation and diminishes respect for the field, compromising its fundamental mission. Although low-cost approaches to some very basic elements of primary care, such as immunizations and treatment of upper respiratory tract infections, make enormous sense, they do not apply to the resources, skill, and training needed to deliver the full spectrum of comprehensive primary care in personalized, coordinated fashion, especially to an aging population with multiple comorbidities. "Provider" belies the complexity and amount of effort required. Note that designation of "provider" has not been applied to such fields as surgery or cardiology, even though these too entail multidisciplinary, team-based care structures.

Respect for the work entailed and sufficient compensation to do the job properly remain key factors with regard to the workforce crisis in primary care, especially as it pertains to physician career choice. Who would want to study long and hard to become an underpaid "provider" in a field that garners little respect and labels its practitioners without regard for the prolonged training and professionalism required? It should come as no surprise that primary care continues to lag far behind specialty fields in medical student opinion surveys and residency selections.[6,7] Although NPs and PAs are understandably gratified to be recognized and designated as instrumental in helping to alleviate the physician workforce shortage by assuming specific responsibilities for which they are well trained,[1-4] their important contributions do not obviate the need for more primary care physicians. Physician participation, if not leadership, in the multidisciplinary team effort remains essential to effectively delivering the full spectrum of high-performance primary care demanded by society.[2-4]

Because the greatly expanded agenda and responsibilities of modern primary care necessitate an evolution from the revered solo-physician model to a multidisciplinary team-based effort, care must be taken to specify competencies, responsibilities, and working relationships of team members while maintaining the traditional commitment to a high level of professionalism. The language used to identify, train, organize, and compensate should reflect specific roles and responsibilities and not obfuscate or denigrate them. This argues for nothing more complicated than returning to use of "doctor (or physician)," "nurse practitioner," and "physician assistant" as the preferred terms for the principal professional members of the primary care team—doing so matches title with level of training and certification. If in some instances an overarching generic term is required, then "primary care professional" might be considered.

The growing demand for primary care and recognition of its central role in rebuilding the US health care system require strengthening support for primary care and enhancing respect for the work of those who deliver it. It is time to cease referring to and treating primary care clinicians (as well as all other physicians and health care practitioners) as "providers" and address and relate to them as the highly trained professionals they are.[8]

ARTICLE INFORMATION

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