It's Time to Retire the Term "Provider" from *JABFM's* Pages

To the Editor: We write with a humble request that the American Board of Family Medicine develop a written editorial policy that explicitly rejects the word "provider" when referring to a physician/Diplomate in all its publications, and that use of the term be eliminated during its journal's editorial process.

The most recent example[1] was published in *JABFM* in February 2023 but the use of the term in *JABFM* has been common: Search Results | American Board of Family Medicine (jabfm.org). Some of the published articles' methodologies indicate only family physicians were part of the study yet the term "provider" was still substituted. Of note, the February 2023 issue published 17 articles (https://www.jabfm.org/search/clinician%20jcode%3Ajabfp%20volume%3A36%20issue%3A1%20numresults%3A25%20sort%3Arelevance-rank) that used the more professional term "clinician" and an editorial and other articles that specified "family physicians." One article used both "provider" and "clinician" to ostensibly refer to the same group.

The American Board of Family Medicine (ABFM)'s own "Strategic Plan 2019 to 2025"[2] states a major goal is to "Promote Professionalism and the Social Contract." Use of the term "provider" represents an assault on professionalism and a fraying of the social contract for economic reasons. This insurance-derived, transactional term has become widely adopted by the health care industrial complex for its own gain to the detriment of the medical profession and patients. The ABFM's "strategic need" is stated as follows: "Commercial pressures, depersonalization through technology, commoditization of health care, and widening social inequities will erode the public's trust in health care. In an environment in which health care is increasingly seen as a business, and professionalism is called into question, our commitment to patients' needs, to the doctor-patient relationship, and to health equity needs to be a part of all we do. ABFM will promote professionalism and the social contract in all its activities, functions, and programs." In this strategic plan document, the word "provider" is never used; the term "physicians" is used 28 times, the word "clinician" once. We believe the JABFM should demonstrate this same level of care when referring to Diplomates in its own journal.

Other journals[3,4] prohibit use of this deprofessionalizing term to describe physicians. The *Journal of Graduate Medical Education* specifically states in its "Instructions for Authors" "Do not use the word, 'providers.' Choose the specific term, or if a generic term is needed, consider, 'clinicians.'" Family medicine organizations (including American Academy of Family Physicians (AAFP) since 2002, reaffirmed in 2018[5], and Association of Family Medicine Residency Directors (AFMRD) in 2022[6] have made this official policy in all communications. ABFM, with its leading role in promoting professionalism and valuing professionalism in a growingly difficult profit-driven health care milieu, clearly needs to do the same.

Last year the Accreditation Council for Graduate Medical Education (ACGME)'s *Journal of Graduate Medical Education* published our article[7] in which we review in detail that calling physicians "providers" has a significant and disproportionately damaging impact on family physicians and family medicine residents, as well as the entire health care team and patients. If physicians are "providers," then for consistency we should think of patients primarily as "consumers," communities as "markets," and our care as a commodity. Rejecting this label is a care quality and physician workforce wellness necessity, emanating from ABFM's core values.

We believe in the importance of words and being precise when labeling human beings. Use "family physician" whenever possible and "clinician" when collectively referring to physicians and other professionals. If you agree, please consider this letter an action item rather than academic discourse. Even if you do not, our direct question is this: Will *JABFM* publish an official position on the ongoing use of this term?

Sincerely,

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Re: It's Time to Retire the Term "Provider" from *JABFM's* Pages

There is information in the *JABFM* Information for Authors on the use of terminology for various health professionals: www.jabfm.org/content/information-authors.

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Re: The Prevalence of Low-Value Prostate Cancer Screening in Primary Care Clinics: A Study Using the National Ambulatory Medical Care Survey

To the Editor: Gillette et al analyze how PSA screening for age 70 and over, a low-value service, is being implemented in the United States.[1]

For PSA screening, the United States Preventive Service Task Force (USPSTF) assigns grade C to those aged 55 to 70 and grade D to all other age groups. By definition, D is not recommended to be done, with solid evidence that the harm outweighs the benefit. In other words, Grade D means that the service should not be performed because it will cause harm to the subject. In addition, C is that the service can not be recommended because insufficient level of certainty of evidence that the benefits outweigh the harms, that is, experimental medicine rather than evidence based medicine. So, in accordance with the Declaration of Helsinki, it is a condition of implementation that subjects are fully informed about the benefits and harms and consents to undergo the service. Grade C is uncertain or zero value and Grade D is negative value. Therefore, if we apply this USPSTF grade to the definition of The Centre for Value-Based Insurance Design (V-BID), PSA screening for aged 55 to 70, grade C, would barely qualify as low value care, but would be out of the question for aged 70 and older, grade D. The authors are not responsible, though, as the V-BID center describes PSA screening for aged 70 and over as low-value care. However, true to the authors' original research intention is a study to analyze how PSA screening for aged 55 to 70 is actually performed in the US.

The authors states, "Currently, it is thought that PC screening confers the most benefit between the ages of 55 to 69 years with the lowest risk of overdiagnosis and overtreatment" In fact, the USPSTF considers PSA screening for aged 55 to 70 as a small possible benefit, many harms (overdiagnosis and complication of tests and treatments), which is essentially a negative value. The USPSTF upgraded from Grade D to C in 2018 but remains Grade D in content.[2] Although there seems to be a negligible benefit when evaluated in terms of cancer-specific mortality, early detection and treatment of prostate cancer does not lead to an improvement in overall mortality because of the overwhelming frequency of other-cause mortality. The only RCT that showed the benefit had an age range of 55 to 70 years, so PSA screening for that age-group was assigned Grade C and the rest were assigned Grade D. The problem of overdiagnosis remains the same for all ages. Overdiagnosis does not mean that there are too many cases diagnosed as cancer, but that the expression "cancer" is overdone. Even if the number of cases can be reduced by excluding indolent cases, this does not mean that the situation will improve. Overdiagnosis is caused by problems with the diagnostic tests: pathologic examination.[2] In addition, the USPSTF also states that the decision to perform PSA screening should be an individual.[1] This means that PSA screening for aged 55 to 70 should be funded by private health insurance or research funding and not by public health insurance. The VHA and Medicare in the US are also public to some extent. It is possible that being covered by these public insurances may mislead subjects into believing that there is evidence of benefit with regard to PSA screening. Strictly speaking, this violates the Declaration of Helsinki.

The authors state as limitation, "First, we only examined primary care PC screening, so we did not include urologists' PC screening behaviors." In practice, screening by urologists would be still very active. Their conclusions are remarkably modest.

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Response: Re: The Prevalence of Low-Value Prostate Cancer Screening in Primary Care Clinics: A Study Using the National Ambulatory Medical Care Survey

To the Editor: We have read Dr. Takahashi's letter and appreciate the invitation to respond. We also thank Dr.

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