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Is There a Doctor in the House? Medical Ethics and the Doctoral Honorific

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INTRODUCTION

In December of 2020, veteran journalist Joseph Epstein penned an “open letter” to Jill Biden, discouraging her from using the honorific “doctor” despite her academic credentials. With perhaps incomplete sincerity, Epstein suggested that “no one should call himself ‘Dr.’ unless he has delivered a child.” This fomented a brief national discussion on the use of the title, the differences between academic and professional doctorates, and the extent to which honorifics figure in systemic sexism or other objectionable social interactions. For health care providers, the conversation was anything but novel. The question of who to call “doctor” has elicited multiple statements of policy from the American Osteopathic Association ([AOA], 2020) and the American Medical Association ([AMA], 2021), as well as statutory regulation in several jurisdictions; in American medical practice, at least, the question is evergreen.

This is partly because the interests at stake are so diverse, though some are weightier than others. Patients have an interest in receiving clear, complete information about the training and competencies of health care providers on whom they rely. Holders of doctoral degrees have an interest in having their accomplishments and expertise appropriately recognized. Speakers of the English language have an interest against being subject to misleading advertising—and against excessive regulatory interference with idiomatic dialogue. People who lack doctoral credentials have an interest in not being made to feel unheard or unimportant as a result. Unfortunately, most analysis of the issue narrows the context or omits important interests from consideration, for example by primarily emphasizing the importance of competent nurses or the stratifying influence of social honorifics.

The desire to keep the issue small is understandable, insofar as use of the doctoral honorific is a relatively low-stakes concern—especially in medical ethics, where disagreement is often literally a matter of life and death. Most attention paid to the doctoral honorific turns on intuitions about pretentious or arrogant behavior, humorous bits about Doctor of Philosophy (Ph.D.s) responding to medical emergencies or appeals to journalists specializing in manners and propriety. This is probably adequate when wondering how to introduce oneself at social gatherings, or whether to use “Dr.” or “Mrs.” when addressing a wedding invitation or thank-you card. But the role of the doctoral honorific in clinical settings is rather weightier. In recent years, the AMA and AOA have taken steps to permit Doctor of Nursing Practice (D.N.P.s) to identify themselves as “doctors” to patients, so long as they clarify, somehow, that they are not doctors of medicine but of nursing. Unfortunately, such clarifications have met with limited success. If care providers are serious about eliminating patient confusion—and they should be—then a careful balancing of interests will show that the title of “doctor” should not be extended to non-physicians in *ad hoc* ways (as regulatory bodies have begun to do) but *avoided altogether* in the context of patient care. Professional and governmental regulatory bodies are likely not capable of decoupling “doctor” from “medical provider” in idiomatic English. However, the elimination of the doctoral honorific from patient care contexts should reduce patient confusion without objectionably undermining the interest that doctors (all kinds) have in seeing their accomplishments and expertise appropriately recognized.

Because many readers will find our proposal radical, we want to be clear from the outset just what it is that we are—and are not—claiming. Our narrow position is that qualified extension of the doctoral honorific to D.N.P.s and similar in clinical settings is a step in the wrong direction, increasing rather than decreasing extant confusion over the title. Our proposed solution is that D.N.P.s should *not* use the doctoral honorific in patient interactions—but also that *physicians*, that is, appropriately licensed Doctor of Medicine

(M.D.s) and Doctor of Osteopathic Medicine (D.O.s), should similarly refrain. Given the prevalence of idiomatic understanding, we do *not* argue for total deregulation of the doctoral honorific; in contexts of medical care, including advertising for health services, regulatory limitations on use of the title remain appropriate. In non-treatment settings, from staff meetings to conferences to social gatherings, we advocate respectful reliance on the doctoral honorific regardless of a person's training pathway. But in the context of clinical care, the medical profession already has numerous training pathway titles on which to rely when communicating with patients. In particular, physicians—already defined by the AMA and AOA—can appropriately and clearly differentiate themselves from clinicians on other training pathways through stable reliance on their *specific*, rather than general, appellation.

AN ABRIDGED HISTORY OF THE DOCTORAL HONORIFIC

The title of "doctor" originally applied to teachers. In Latin, *docēre* means "to teach," and academic doctorates were, at their inception, "a license to teach and nothing more" (Van Scoyoc, 1962, p.322). As *licentia docendi* evolved into something more, so too did universities and the doctors working within them. Thus, by the time William Tyndale produced his 16th century translation of the Holy Bible—the first English edition of that work—he rendered the Greek *nomodidaskaloi* as "docturs of lawe" (Luke 5:17). Today, translation software is more likely to identify *didaskaloi* as "teachers," but in Tyndale's day the agentive noun connoted *demonstration*, making "doctor" the better word for pedagogy of a more theoretical sort. By the 17th century, William Shakespeare was making liberal use of "doctor" to identify physicians, but as academics may note when their claim to the doctoral honorific is challenged, at that time the study of medicine was still dominated by Hippocrates' four humors. By contrast, Gottfried Leibniz took a Doctorate in Law from the University of Altdorf in 1666 and independently invented calculus in 1675.

English-speaking academics and physicians have on occasion *stopped* styling themselves "doctor," for example amidst a 19th century explosion in the use of the (then, unregulated) title by charlatans—that is, "quacks" (A Man of the World, 1889, p.124). Thence, attempts to regulate or deregulate the doctoral honorific became perennial, as institutions of higher education, medicine, and journalism wrangled with popular perception and propriety. The title of "doctor" was historically a signal that its bearer possessed sufficient expertise to helpfully instruct others on complex matters—like mathematics, medicine, or morality. But because expertise in many contexts also engenders social *status*, the unscrupulous can arrogate social status by simply adopting the title or, in other words, by faking the signal. When fake signals become sufficiently widespread, the authentic signal loses its value. This gives doctors two separate, but related, reasons to be protective of the doctoral honorific. One of these is essentially selfish: if the doctoral honorific stops conferring social status, it is of less value to both authentic and inauthentic bearers. The other, however, is a matter of public good. When the doctoral honorific fails to reliably track bearer expertise, people who need to consult an expert must rely on alternative identifying signals. This explains why academics and physicians eschew the doctoral honorific in times when it proliferates: by clarifying their exact credentials (for example, via post-nominals) and shedding the doctoral honorific, experts can distinguish themselves from charlatans while continuing to signal their expertise to the public.

The late 20th and early 21st century has witnessed a new proliferation of the doctoral honorific—but instead of pretentious charlatans, this latest proliferation owes its genesis to explosive growth in higher education. Initially, the regulatory efforts of the late 19th and early 20th century held sway, for example with lawyers holding Juris Doctor (J.D.) degrees proscribed from using the title "doctor" either "professionally or socially" (American Bar Association, 1968, p.657). These proscriptions did not last, though it is still unfashionable in most contexts for lawyers to style themselves "doctor." In many jurisdictions, all that remains of the original proscription today is the admonishment that lawyers must avoid client confusion. Meanwhile, between 2000 and 2018, the number of Americans holding doctoral degrees more than doubled, from about 2 million to over 4.5 million (America Counts Staff, 2019). In addition to J.D.s, a host of D.N.P.s, Doctor of Education (Ed.D.s), Doctor of Physical Therapy (D.P.T.s), and others have swelled the ranks of American "doctors" who are not physicians, theologians, or research academics. While

individuals holding such degrees may be personally ambivalent about the doctoral honorific, program advocates tend to emphasize “equivalence” with other training endeavors, as well as highlighting the *per se* importance of advanced study in their respective fields. Because many of these programs disproportionately attract female students, efforts to proscribe use of the doctoral honorific have also been met with accusations of sexism—prompting some journalists to update their style guides in favor of applying the doctoral honorific to non-physicians (Ryan, 2018).

THE INTERESTS AND ETHICS OF HONORIFICS

We take no position on the cultural propriety of the doctoral honorific; style, manners, and aesthetics are not our concern. But in some contexts, the use or proscription of the doctoral honorific bears ethical implications. Specifically, we think that behavior is morally permissible when it does not violate a principle “for the general regulation of behavior that no one could reasonably reject as a basis for informed, unforced general agreement” (Scanlon, 1998, p.153). This approach to gauging permissibility is known as contractualism. The “ideal to which contractualism appeals” is “that of being able to justify your actions to others on grounds that they could not reasonably reject” (Scanlon, 1998, p.154). Principles that cannot be reasonably rejected are informally identified by weighing the costs they impose on the interest’s people have, against the costs imposed by alternative principles (Scanlon, 1982). Moral theorists writing on bioethics are often concerned with extremely important interests, like the interests we all have in staying alive, being healthy, and living autonomously. Where important interests are at stake, the range of morally permissible actions can be quite narrow; principles imposing costs measured in life or liberty must be justified by even weightier interests, or else rejected.

Use of the doctoral honorific is not, we think, an especially weighty matter. Indeed, to many, honorifics are trivial at best, and insisting on a certain “correct” pattern of usage can come across as exceptionally vain. Conversely, refusing to adopt such patterns can seem pointlessly disrespectful—even bigoted. But whether a pattern of speech is idiomatic, polite, or fashionable has little bearing on whether it is *morally permissible*. It would be tacky, even impolite, to address a wedding announcement to your physician friend, “Ms. India Johnson.” Would it be *morally blameworthy*? This depends a lot on the details of your relationship with Dr. Johnson, because those details are relevant to the justification you will be able to offer, and the sorts of justification she could not reasonably reject. This also applies to Dr. Johnson’s eventual *response*—or, indeed, anyone else’s. Even if we assume that mistitling Dr. Johnson is morally blameworthy, it seems unlikely that the AMA could permissibly levy a fine against you for the insult. Contractualism is not concerned with identifying what is *optimal*, morally, or otherwise. The question with which we are concerned is whether and when, ethically speaking, the doctoral honorific can or must be regulated. To answer that question, we must consider the interests at stake.

Everyone has an interest in being addressed respectfully by others, but we also have autonomy interests against being punished for speaking our minds. Our interest in expressing ourselves freely is often regarded as sufficiently important to be recognized as a fundamental right—in the United States, enshrined in the First Amendment to the Constitution. Even our important interests are, however, defeasible; impositions on the way we speak can be justified when yet-weightier interests are at stake. American courts have recognized several such interests, permitting government-sponsored regulation of speech including incitement to violence, obscenity, and—of particular relevance to the present inquiry—commercial speech. Regulation on the advertisement of medical products and services is today commonplace, and closely related to the requirements of education and licensure imposed on clinicians of various kinds. The usual justification for such paternalistic regulation is that people have an important interest in receiving competent care but are often poorly positioned to personally identify competent clinicians. Regulation of the doctoral honorific has long been one small piece of a larger regulatory scheme aimed at empowering the public to confidently rely on the expertise of medical care providers. Thus, for the better part of the 20th century, non-physicians in health care contexts were forbidden by regulatory bodies from identifying themselves as “doctors,” even when they held doctoral degrees. The interest non-physician doctors have

in recognition of their expertise was not regarded as sufficiently weighty to underwrite rejection of a patient-protecting principle forbidding non-physicians from identifying to patients as “doctor.”

What changed? We think two historical developments underpin 21st century shifts in attitude toward the doctoral honorific. The first is growing social recognition of the interest individual women have in their expertise not being dismissed by virtue of their sex. The second is the proliferation of doctoral degrees in the early 21st century—a phenomenon overwhelmingly driven by women (Perry, 2020). Previously, insisting on one’s doctoral title was often cast as pretentious; the primary interest being weighed was a legitimate but, ultimately, self-serving desire for recognition of one’s personal accomplishments. When it was recognized that men tend to dispense with formal titles when introducing women in professional settings, but not vice versa, and noted that this might unfairly disadvantage women, insisting on one’s title came to be recognized as a *response* to potentially discriminatory behavior (Files et al., 2017). Since we all have an important interest in living in a society where our sex (or race, or religion, or similar) is not regarded as contraindicating expertise, principles forbidding doctorate holders from use of the doctoral honorific fell under new suspicion. Perhaps such principles could be reasonably rejected after all, as hampering the ability of some to be recognized as equals in professional contexts.

But if our normative gloss on recent trends is a good fit, it raises a question: does a principle permitting DNP’s or other non-physicians to identify themselves *to patients* as “doctor” adequately account for the interest patients have against being misled? In contexts like academic conferences, staff meetings, or social gatherings, a principle forbidding holders of doctoral degrees from identifying as doctors can, it seems, be reasonably rejected; the interest in having one’s expertise appropriately recognized, regardless of sex, does not appear to be outweighed by any competing interests in those contexts. Whether one holds a Ph.D., Ed.D., M.D., D.N.P., or even a J.D., the doctoral honorific can be appropriately and ethically applied in non-clinical contexts, even if some people do find it pretentious or embarrassing. But the context of medical treatment is different. There, patients are much more likely to rely on an idiomatic interpretation of the doctoral honorific—that is, most people think “doctor” means “physician,” even when attempts are made to explain the difference. For most people, the history and nuance of the doctoral honorific will be uninteresting and attempts to educate them may be confusing—or unwelcome. Patients seeking competent medical attention are overwhelmingly likely to have weightier matters on their minds.

While the revised policies of the AMA and AOA pay lip service to permitting broader use of the doctoral honorific while avoiding patient confusion through clarificatory disclaimers, empirical evidence suggests that confusion persists. In one recent survey, 39% of respondents believed that a DNP qualified as a “physician,” with another 11% uncertain—only half clearly understood DNP’s to *not* be physicians (AMA, 2018). Indeed, role-title confusion concerning DNP’s persists not only among the general public, but among medical care *providers* (Uldis & Mancuso). Given the extent to which the public was *already* confused about the “kind of care . . . [physician’s assistants (PAs) and nurse practitioners (N.P.s)] are able to deliver in comparison to the more widely understood physician profession” (Parrault & Hildebrand, 2018, p.1857), it may simply be asking too much for a significant number of patients to meaningfully grasp the nuance of “Doctor Nurse.” If a patient’s autonomy interest against being misled is weightier than a clinician’s respect interest in being called “doctor”—and we think that it is—then patients can reasonably reject a principle allowing non-physicians to identify themselves as “doctors” in a treatment setting, *even if they also clarify their clinical role*. While clinicians all have an interest in appropriate recognition of their expertise, there are other ways to make one’s expertise known than by insisting on the use of a potentially confusing title. Contrary to recent trends in policy-making, regulatory bodies should *not* permit the use of the doctoral honorific by non-physicians in treatment contexts.

This is not, however, the only implication borne by a balancing of interests between patients and providers. Given the generic nature of the doctoral honorific and its recent proliferation, patients *also* cannot be appropriately regarded as fully informed by a physician’s reliance on the doctoral honorific. Empirically, more than one in ten respondents to an AMA survey either did not think that, or were unsure whether, surgeons, obstetricians, and primary care physicians qualified as “physicians.” Another recent poll

showed that patients rely with alarming frequency on the wearing of stethoscopes and the *color of scrubs* to clue them in to their clinician's level of expertise (American College of Emergency Physicians, 2021).

Meanwhile, a physician's own claim to the doctoral honorific, while idiomatic, is grounded in the same personal interest in recognition of expertise held by every other doctoral professional. While idiomatic English makes patient confusion *less* of a concern for physicians using the doctoral honorific in treatment contexts, some confusion persists, and doctoral professionals like DNPs still have a fairness interest in not having their expertise disregarded in contexts where physician expertise is acknowledged. Thus, in treatment contexts where non-physicians are obligated to refrain from use of the doctoral honorific, physicians should *likewise* refrain.

ROLES AND HONORIFICS IN OTHER TIMES AND PLACES

While our proposed solution obviously challenges the status quo—for physicians and other doctoral clinicians alike, given recent trends in policy-making—we think it better aligns with broader trends in history and language. As observed in Section 1, there is historical precedent for physicians eschewing the doctoral honorific when it proliferates, so as to preserve public trust in the profession. The 21st century explosion in duly granted doctoral degrees is a different kind of problem than the 19th century explosion in quackery, but its relevance to the practice of medicine is essentially the same: increased numbers of non-physician doctors mean physicians need a finer-grained approach to public messaging. By clearly communicating roles and clinical training pathways rather than relying on generic honorifics like “doctor,” providers appropriately recognize the patient interest against being misled. This may even be less of a departure from the status quo than it might initially seem; regulatory bodies have *already* promulgated numerous titling guidelines in connection with roles like “physician's assistant” and “nurse practitioner” (though it would likely be of additional help to patients if care providers did not routinely abbreviate their role to an alphabet soup of postnominals). The word “physician” itself is already clearly reserved by the AMA and AOA to licensed M.D.s and D.O.s. Physicians in treatment settings already have good reason to identify themselves as physicians, then, since identifying as “doctor” under current rules no longer clearly distinguishes them from D.N.P.s or other non-physicians with doctoral degrees.

The extent to which confusion or clarity can result from the relationship between titles and roles can also be seen when looking abroad. In the United Kingdom, for example, the doctoral honorific is but inconsistently regulated—though there is a long-running argument, stemming from the deprecated role of “barber surgeon,” over the tradition of referring to surgeons as “mister,” “missus,” or even “miss” (Laurance, 2005). The standard degree for physicians in the UK is the Bachelor of Medicine (M.B.) degree, affording its holders the doctoral honorific based on role rather than title—while surgeons, who typically begin with an M.B. degree and then secure additional training and certification, essentially *shed* the doctoral honorific. The recent rebellion of surgeons against this historic norm tracks nicely with our concerns about reducing patient confusion and appropriately recognizing physician expertise, though (like American physicians) physicians in the UK would be well-served to avoid the doctoral honorific entirely in treatment contexts.

To consider a less anglophone example: in Germany, where *many* honorifics are strictly regulated, the title of “Doktor” is afforded to academics who complete a research thesis within the European Union. Physicians who complete the “Dr. med” degree alone are referred to as *Arzt* or *Ärztin*—a “physician” who is afforded no particular honorific beyond the “Mr.” and “Mrs.” equivalents *Herr* and *Frau*. But “Doktor” is also employed idiomatically as a noun referring to the clinical practitioner with a medical doctorate. Patients often address their physician as “Herr Doktor” (which would revert to “Herr Müller” if the patient is of comparable academic rank). Completion of additional academic theses accrues additional titles, so colleagues might respectfully refer to a physician with dual theses as “Herr Doktor Doktor Müller,” while patients would address the same physician simply as “Herr Doktor” (Schneider, 2016). While Germans do not universally regard this as an improvement over the British system (Groneberg, 2001), we think that the

separation between modes of address from colleagues versus patients partially instantiates the approach for which we advocate here.

These examples help to illustrate the relative ubiquity of the challenge—and the workability of our proposed response. We do not think that medical professionals need to engage in a robust campaign of linguistic reform; indeed, we are skeptical that such a thing would be either wise or practicable. Rather, we think extant debate over the doctoral honorific has generated counterproductive responses from regulatory bodies, imposing objectionable costs on patient interests by extending the doctoral honorific to non-physicians. We further believe that a solution may be found in history and linguistic tradition, through increased reliance on role- focused titles in treatment settings. The doctoral honorific has *never* been the sole province of physicians, and so should be liberally afforded to doctorate holders in social and professional settings—but should be eschewed entirely in treatment contexts. Physicians should introduce themselves to their patients as *physicians*.

CONCLUSION

In clinical settings, most patient care can be competently handled by mid-level practitioners, non-physician providers, or advanced care providers. But some pathologies require significant exposure and diagnostic acumen, only acquired after thousands of clinical hours. No wonder, then, that most people who seek medical care prefer to be attended by a physician (Leach et al., 2018). This creates a conundrum for a nation anticipating a shortfall of 139,000 physicians in the next 12 years (Boyle, 2020). If most patients prefer to see a physician, but there aren't enough physicians to go around, then some people are not going to get what they prefer. If a qualified DNP, in the course of providing competent care, were asked to send in a "*real doctor*," it would be understandably tempting to retort, "*I am a real doctor!*" Capitalizing on patient confusion to reduce their dissatisfaction while nevertheless providing them with the care they need is fundamentally paternalistic. While we do not think paternalism is always wrong, it must be justified by a weightier interest than the patient's interest against being misled. We do not think that a nurse's legitimate interest in being suitably respected by his or her patients is generally sufficiently weighty in this regard. Patients should be told when they are not being seen by a physician, even if this reduces patient satisfaction with substantively adequate care.

This is in part because the cost of patient deception, while often minimal, can at times be quite significant. A case related by physician Niran Al-Agba (2017) illustrates the point. A new mother was referred to a pediatric specialist, Dr. Jones. She expressed concerns about her baby's heart health, but Dr. Jones insisted that there was nothing wrong with the child's heart. When the child failed to gain weight, Dr. Jones ultimately referred the mother to Child Protective Services for neglect. While interactions with Child Protective Services can be shockingly fraught, the bureaucrat assigned to this case started by recommending the mother seek a second medical opinion—which identified a heart murmur and led to the eventual diagnosis of two septal defects and Total Anomalous Pulmonary Venous Return. The pediatrician who made the correct diagnosis was a physician; Dr. Jones, by contrast, was a D.N.P. Even assuming Dr. Jones clearly posted his credentials, honestly explained his training pathway, and never willfully misrepresented himself, the mother in this case trusted his expertise as a pediatric *doctor*. Until Child Protective Services got involved, it had apparently never occurred to the mother to seek a more qualified authority—suggesting that she either did not understand the difference between a DNP and a physician or did not understand that her baby's "doctor" was a D.N.P.

Anecdotes along these lines are commonplace among physicians; patient confusion is a hard and persistent problem. But forbidding D.N.P.s or other non-physician doctors from employing the doctoral honorific—as was the standard for most of the 20th century—only partially addresses the interests at stake. To achieve maximum clarity, the misleading doctoral honorific will need to be discarded in *all* patient interactions. Patients have the right to receive medical care, and to refuse medical care. One may refuse medical care based upon knowledge of who the care provider will be. Obfuscation of clinical roles only makes patient rights more challenging to appropriately ensure. The best way to orchestrate patient rights

is to refer to all practitioners—physicians, physician’s assistants, nurse practitioners, and so forth—by their appropriate clinical title. One would not refer to BSN-trained nurses as “bachelors,” or health administrators as “masters.” It is time for physicians to follow suit and relinquish the doctoral honorific in contexts of care.

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