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Geri Amori, PhD, DFASHRM: Hello, everyone, and welcome to *Healthcare Perspectives 360*, a podcast dedicated to exploring contemporary healthcare issues from multiple perspectives. I'm Geri Amori, and today I'm joined by Benjamin Drum, MD, PhD, an Assistant Professor in Internal Medicine and Adjunct Professor in Pediatrics at the University of Utah; Julie Samora, MD, PhD, who is a pediatric hand surgeon at Nationwide Children's Hospital, where she is Associate Chief Quality Officer and Director of Quality Improvement within the department of orthopedics; and Tatum O'Sullivan, RN, who is a senior consultant with AON Global Risk Consulting Team and the current president of the American Society of Healthcare Risk Management. Welcome.

Today, we're talking about how impostor syndrome may be almost unescapable for healthcare clinicians. Healthcare has changed in the last 50 years and with it healthcare education. When my husband went to medical school, he was told, on the first day, that he was responsible for knowing all the answers. He couldn't expect his nurses or other staff to have the depth of knowledge he was supposed to have. And he certainly couldn't expect patients to know anything. He tells the story to make the point that it was scary to be told you had all that resting on your shoulders. And certainly at that time, it was more difficult to get information quickly. But there was also less information to be had.

Today's physicians are trained in the world of the internet and AI. They are taught that they won't be able to hold all the information in their heads, and so they must learn to be good investigators, to ask the right questions, and to be able to hone in on the answers. What we are hearing about increasingly is that today's physicians are not more confident because of all the resources that are available to find answers. We are learning that increasing numbers of them experience what is known as "impostor syndrome." Impostor syndrome is defined as "chronic feelings of self-doubt, the fear of being discovered as an intellectual fraud, a perception of being less intelligent or competent than peers, and an inability to internalize a sense of competence, of skill in high-achieving individuals." And although the students and residents are told they cannot know everything, they feel they should have most, if not all, the knowledge in their head.

Furthermore, while we joke that many of the physicians of my spouse's generation acted like Dr. God, we don't really know if that behavior was because they truly felt they did know all the answers, or they feared that they didn't and couldn't show it. Could they have had impostor syndrome, as well? Perhaps our modern clinicians are simply more willing to admit it. And impostor syndrome has been a hidden problem for many years, creating an unhealthy situation for all clinicians. This all raises the question of whether impostor syndrome is endemic to healthcare professionals. And if so, what can both the healthcare system and our society that relies on our healthcare professionals do to make the profession psychologically healthier for healthcare givers?

So tonight, we are going to ask our panelists about that. Dr. Samora, may I call you Julie?

Julie Samora, MD, PhD: Please do.

Amori: Thanks. Julie, how does impostor syndrome develop in clinicians? Is it sudden, or is it gradual? Or does that kind of depend?

Samora: I think that impostor syndrome disproportionately affects high achievers. So this phenomenon begins early in life. Top performers tend to have perfectionist traits, such as setting incredibly high standards, being highly motivated, and being self-critical. Healthcare professionals, in particular, hold themselves to a high degree of excellence, which I think predisposes them to impostor syndrome. So, to answer your question, I believe some aspects of impostor syndrome are present before the healthcare career even begins.

Amori: Wow, that's something to think about. Before they even get started. So, Dr. Drum, Ben it is, right?

Ben Drum, MD, PhD: Ben is great.

Amori: Studies of US medical students suggest that 20% to 50% of US medical students have substantial impostor syndrome. What facets of medical school are there that drive this? And are there facets of the medical school selection process that drive this?

Drum: Yeah. Just like Dr. Samora was saying about that idea of perfectionism. When we think about doctors and getting into medical school, we think about, wow, it's so hard, and you have to be almost perfect to get in. And so, we're bringing that idea of perfectionism even before people start studying, and 40% to 50% of undergraduates actually think they want to start premed. And so, you get half of college kids wanting to be premed, and then they get whittled down by organic chemistry and biochem and all these other things. And so, you see so many examples of failure, that it's…you see way more examples of failure and people dropping out of premed than success. And so, in some ways, the competition actually makes it easier to believe, wow, maybe I'm someone who just forgot to drop out.

The other factor I think about when I think about impostor syndrome in our medical education system is that our assessment tools aren't super predictive of how well people do, and they actually don't even have a lot of applicable knowledge as to how well people do. So, for example, everyone has to take the MCAT to get into medical school. And the MCAT mostly consists of pretty esoteric knowledge about biochemistry and O-chem. And you get to medical school, and you did really well on the MCAT, and then you find out that a lot of what you learn on the MCAT doesn't matter. And we don't use it in medical school, and you have to learn everything for step one. And then you take step one, and that also has lots of basic drug mechanisms and things we don't really use in residency. And so, you do really well on step one, and then you get to residency and you're like, wow, everything I did well on actually doesn't matter. And the game has changed. And so, if the game has changed, it's hard to know if you actually are fitting in

and succeeding, or if you just passed the last level, and now you're not equipped for the new one.

Amori: So, it's kind of like you're in a race, and they keep changing the race while you're running it.

Drum: Absolutely.

Amori: That's what it sort of sounds like. Yeah. That's hard. That's really hard. Ms. O'Sullivan, may I call you Tatum, please?

Tatum O'Sullivan, RN, BSN, MHSA, CPHRM, DFASHRM, CPPS: Yes, of course.

Amori: Thank you. One quote that struck with me, as I reviewed the literature, was that impostor syndrome plagues those who are, and here's the quote, "striving for excellence in a sea of excellence." Now, we know how competitive it is to get into medical school, as Ben was just saying, and once there how both the desire to excel and the fear of failing enters in. And, as Ben just said, the game gets changed while you're running it, right? This is further exacerbated by our American cultural ideal, I think, that you can do anything you put your mind to. At least that's what most of us are told when we're young. Could it be that medicine in general, not just medical school, self-selects for those vulnerable to this psychological state?

O'Sullivan: I think that's definitely a possibility. If you think about nursing school or medical school, you go into those programs with all your eggs in that one basket. If you go through four years of nursing school, it's expected that you're going to come out and be a nurse. It's expected at the end of medical school that you're going to come out and be a physician. And you have to excel. You have to do well. You don't want to be trailing behind or the weak link in your program. And so, there's this need to keep proving yourself and excelling in the profession. I think that that's something that definitely a lot of nurses that I have seen take with them.

I remember going back to my nursing school days—it was pretty long ago—but I do remember going back and thinking, is this really the profession for me? If it isn't, it doesn't translate well…your credits don't transfer into an accounting program or to teach, necessarily, and so there's this pressure to do well. And a passing score doesn't necessarily mean that clinically or skill-wise that you're meeting the needs. And so, when you're out there with patients, you really have to prove yourself, and you look for validation wherever you can get it. And you're hoping that your professor is telling you that you're doing well. You hope that your patients trust in you. But it's really hard to carry yourself with confidence when you're learning.

Amori: So, back to like what Ben was saying, they keep changing the game while you're in it. And you're saying then you go out and you see patients, and it's a whole new game altogether. So, the game keeps changing. It's hard to know how you're doing. Julie, if you don't mind, historically, healthcare clinicians are reluctant to seek mental healthcare.

They're usually afraid of medical boards finding out. How might this affect the development of impostor syndrome?

Samora: It's true. Many clinicians do not seek help, and they fear appearing weak if they do seek help. Oftentimes, they don't think they need or even know they need assistance. During the pandemic, I was probably in clinical depression but didn't recognize it until I was on the other side and probably could have used some assistance. Unfortunately, without some form of indicated mental healthcare, healthcare providers may dwell on the negatives. They may spiral downward. They could avoid new opportunities. They might minimize their successes. And they could have difficulty interacting with others due to self-doubt. All of these issues could exacerbate impostor syndrome.

Amori: Ben, you wanted to say something about that.

Drum: I was just so struck by that idea of being in depression and not recognizing it. And I think that is so common in medical providers because our training is to disregard our own feelings for the sake of the care and the sake of the patient. We're often taught, like, we are the givers of care, and we're using evidence-based medicine. And we're there to do no harm and enact the oath, but sometimes that's to the detriment of how we're processing and conceptualizing really heavy emotional things. And oftentimes, we run a code, and then we have to turn around and go to the next room or have a difficult patient conversation or have a disruptive patient, and we just kind of have to leave out the door because every patient deserves the best care that's independent of what happened before us.

And so, it's so easy at the end of my day to find that I've stuffed all the emotions from the day and not had time to process them. And in something like the pandemic, that can happen for weeks or months, and then you turn around, and you realize, wow, I don't know what happened to me. And so, I think that is on an individual level, like Dr. Samora said, but that's also at systems level in terms of how we're training our physicians to not be in touch with our emotions and to separate who we are from how we enact care. And I think trying to be more human in our care and acknowledge our own feelings can go a long way.

Amori: So, you've had that experience and know about that experience from the physician perspective. And I'm wondering if you think it's different for PAs or nurses. What are your thoughts, Ben?

Drum: I think anywhere in healthcare, you're going to be running into a job that's really high stakes with high expectations, high emotions, and little margin for error because we really want to do the best care for every patient, right? We're dealing with people's healthcare and their lives. And so, regardless of where your job is in healthcare, you're going to have that exposure to this system and be at risk for impostor syndrome. Thinking about what that looks like for me as an attending physician versus a nurse…obviously, I can't totally speak to a nursing perspective. The things that I see from nursing is that they're often almost sandwiched between the patient and the physician. And so they

spend so much more time with the patient. They're asked so many more questions, oftentimes.

And then from a physician standpoint, we rely on them to be the front lines and the eyes and ears of if something is worrisome to contact us. And so, there's more pressure from almost the patient and the physician, which I think, obviously, would exacerbate impostor syndrome and not knowing if you're actually doing the right thing with all that pressure. On the converse side, I think nursing can have more support, sometimes. So, they have a charge nurse, and they do have an attending physician that they can go to if things are getting out of control, and they know that there are other people to reach out to, whereas, as an attending physician, I'm kind of the final step. And so, I can talk to a colleague, but it's a little bit different. And so, that's maybe a protective factor, is that there's maybe an extra layer of supervision, likely reversed by the fact that they're a pressure tank, so to speak.

Amori: That's really insightful to see how a physician might look at what's going on for nurses. Thank you. And it sounds like they're the sandwich generation of healthcare givers, right? They're stuck. They're between the patient and the doctor. So, let's ask Tatum because, Tatum, you are a nurse, and you work with nurses, and you're a risk manager. From your perspective, what is it like for nurses?

O'Sullivan: For nurses, there are those layers of assistance and help when you're on the floor. So, you do have a charge nurse, or you have your nurse manager. You do have somebody that you can go there and ask, but you also have to feel comfortable doing that. That's half the battle. And then I think about advanced practice nurses. And those programs have changed a lot in the past few years…well, probably longer. But what I'm seeing now is a lot of advanced practice nurses, nurse practitioners who come out of their programs have no clinical background. They're a change of careers. And so, back in the day, a nurse practitioner would be somebody who worked in an ED or worked in the ICU, and they had a very high skill level going into it. And these nurse practitioners are being asked to diagnose and treat, and they may have never seen this condition before.

As a risk professional, I will tell you that what I have seen is that sometimes they get the diagnosis wrong, and they knew that they should have asked for help or should have run something by somebody else, but they didn't feel comfortable doing that. And that's a real problem in healthcare, that people don't feel comfortable asking. And so, they're faking it till they make it, but sometimes you don't make it, and that's the scary part.

Amori: That's very scary. Well, as you know, there's one question I like to ask our panelists every topic we talk about. And with today's topic of how prevalent is impostor syndrome, I'd like to ask you each if you have only one thing that you would like our audience to take away from today's podcast, what would that be? Julie, I'd like to start with you.

Samora: I think the takeaway for today is that we should normalize impostor feelings such as anxiety, a lack of confidence, fear, and expected knowledge deficits early on in

training and in our careers. In a nutshell, impostor syndrome is normal. The more we recognize it, the more we normalize it, the easier it is to address it.

Amori: Okay. Thank you. Tatum, what would be your one takeaway for today?

O'Sullivan: I think it's important to remember that nursing, as a profession, is known for eating its young. It's a horrible statement, especially in healthcare, but it's true. And we need to change that. And I think it is changing because it's a statement now that many of us know. But with impostor syndrome, you really want to keep the doors open for conversations and questions. I think what Julie talked on is right on point—that it's okay to ask questions to recognize that, oh, I have to step up a little bit, but I can look up something before, I can talk to somebody before. And so, I think that my big takeaway for this is that, really, it's okay not to have all the answers. And we need to normalize that a little bit of impostor syndrome probably exists in everybody or should or could, and it's okay to acknowledge that and get the tools that you need to do your job.

Amori: Thank you. All right. Normalization. That seems to be a theme here. Ben, what would you like to have? What would be the one thing you would want our listeners to know today?

Drum: I would say, if you have impostor syndrome, you're not alone. Healthcare, like I said, it's incredibly stressful. It's challenging. It's high stakes. It's emotional. And that's a breeding ground for impostor syndrome. So, if you're struggling with it, you're not alone.

Amori: Thank you. Thank you. This has been truly a great discussion. And I want to thank our panelists for participating. Please join us in our next discussion, which will be digging further into the details of what impostor syndrome looks like and its effects on clinicians. I hope our listeners found this valuable. I know I did. And thanks again for joining us.

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