

Gerri Amori, PhD, DFASHRM: Hello, everyone, and welcome to *Healthcare Perspectives 360*, a podcast dedicated to exploring contemporary healthcare issues from multiple perspectives. I'm Gerri Amori, and today I am 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 risk consultant with the AON Global Risk Consulting Team and current president of the American Society of Healthcare Risk Management. Welcome.

Today, in our episode, we're going to talk about methods to combat imposter syndrome in healthcare clinicians. We've had several discussions about imposter syndrome, and we're ready now to kind of say, what do we do about it? I'm going to start with you, Ben. In the article that you've written, you say, "I don't remember a time in my medical training without the looming shadow of the imposter. I've reimagined how to manage, rather than cure, imposter syndrome." This poignant confession leads me to ask, how have you managed imposter syndrome?

Ben Drum, MD, PhD: Thanks for asking that question. I'll start by just saying I'm by no means an expert, but I can definitely share kind of what I've found useful for me, and maybe it'll be useful for other people. The quote you mentioned talks about this idea of managing rather than curing, and that was kind of one of the first pieces I had to navigate. I really wanted to just get rid of imposter syndrome and say, I just need to push through it, get past it, pretend it doesn't exist, whatever. And that's just not practical, right? Like, I've had imposter syndrome my whole training. And if I've had it for 16 years, there's probably part of me that finds it really helpful and protective and part of me that wants to keep it going. I probably won't be able to cure it in a month or a year or the rest of my career. And so, getting to that level of, that stage of grief, of acceptance, if you will, was kind of step one.

And then I think, furthermore, just adjusting my own expectations. We talked earlier about that idea of perfectionism in medical education and in medicine. And I think for a long time I thought my standard needs to be 100%, and if I do a really good job, that is normal, and if I miss something, then that is wrong. That's a good goal. But as you go further in medicine, you realize that everyone makes mistakes, and we're all human. And so, I've learned to kind of, both with myself and my learners, normalize the mistake culture. The first day of a team with residents, I say, I'm going to make a mistake this week. You're going to make a mistake this week. Everyone's going to make mistakes this week. The question is, can we be honest about them? Can we learn from them?

And by normalizing that mistake culture, I feel like that is helpful because it sets the bar a little bit lower and also allows that idea of accepting gratitude when you do a good job. I think my first year in residency and as an attendee, if a patient thanked me, I would just say, I did my job as a doctor. And now I've learned to actually cherish those moments when a patient thanks me and say, actually, like, I helped someone. And that wasn't just

because that was what my job was to be. It's because I actually did a good job as a physician. And I think those moments take me past imposter syndrome.

And I guess the last thing I say—I know I've talked a little bit already too much—but giving myself permission to just accept where I'm at in the day and accept my own emotions. Take the time, take 5 minutes, after a difficult conversation, to actually have that debrief and ask myself, what am I feeling right now? Am I feeling my heart race? Am I feeling tightness in my shoulders? And normalizing that, saying, that's actually a normal human response. Like, that's not me not doing my job and letting my emotions get the better of me as a physician. That's me realizing this is really hard, and it's okay to process that and feel that, and even share that with the patient sometimes and saying, I hear you're getting frustrated, and I'm feeling your tension myself. I wonder how we can work together on this.

And sometimes that means not wearing a white coat. If I'm feeling like an imposter and the white coat is making me feel like a clown and a fraud, then I'm not going to wear it that day. You know, the white coat is always there to come back to. And sometimes it's helpful, and it makes me feel more like a physician, and sometimes it's not helpful. And so, just giving myself the liberty to know what I need as a physician in that moment and be more in touch with my emotions and set that bar a little bit lower has made a big difference for me.

Amori: Wow, that is truly beautiful and thank you for sharing so much. Do you mind if I ask you just a little more prodding question here?

Drum: Absolutely.

Amori: You said that sometimes the imposter syndrome can be a little protective, and I thought that's interesting. Can you expound on that just a hair?

Drum: Yeah. I mean, I think back to my medical education, and there was a time when step one was not pass/fail, and it mattered a lot what score you got. And I studied for 5 weeks straight, 13 hours a day because I was terrified that I wasn't going to pass the test, and I wasn't going to get the grade, and I was going to be found to be an imposter. And so, was that healthy? Maybe not totally, but it did help me get where I needed to be, and I got a good score. And so, thinking through just kind of all the things that happen in medicine, I think the imposter has pushed me to try and do my best and also has given me that healthy pause when something isn't right and not trying to push through and think, oh, I got it. Being like, oh, actually, like, maybe I don't got it. And having that pause to promote a culture of safety. I think the imposter kind of helps that, as well.

And I guess one other thing I would add to that first question is, in addition to the things I said, the biggest thing that I've done has been really open about talking about imposter syndrome, talking about, when I talk with my learners about expectations, I say, you may be struggling with imposter syndrome, and that's normal, and that's okay, and I have that, too. And if you are, or if you're struggling with burnout, let's talk about those things and

not pretend they don't exist. If I see a colleague in the hallway, and I'm having a rough day, I'm open about that. And I think sharing your imposter syndrome and putting them in the light actually makes the imposter a little bit less scary.

Amori: Thank you. That is very human and very beautiful. I appreciate that, and I'm sure our listeners do too. Hey, Julie, you also have written an article about this, and you say, in it's a supportive environment, there may be situations where a small amount of imposter syndrome may be ideal. And can you tell us more about where imposter syndrome, from your perspective, might be a positive thing?

Julie Samora, MD, PhD: Sure. As a surgeon in an academic setting, I train about 60 to 70 orthopedic residents a year, as well as various fellows. I would much rather have a trainee with a bit of underconfidence than one with a lot of overconfidence. It's scary when a junior resident is overly confident—we're going back to that Dunning-Kruger effect—taking that scalpel straight from skin to bone without recognizing that there might be tendons and vessels and nerves that could be in the way. And so I would much prefer working with a cautious and careful resident, dissecting slowly, and maybe desiring a bit of guidance as they begin their surgical journey.

Amori: Okay. Yeah, that makes sense. I would too, especially if they're operating on me, right? I'm glad you're there to teach them. Tatum, you work with a lot of healthcare professionals in your role as a risk management professional, and as your role as a nurse, and as a well-known advocate for addressing burnout in healthcare. What do you recommend for addressing imposter syndrome in our clinicians, from your perspective and in our system?

Tatum O'Sullivan, RN, BSN, MHSA, CPHRM, DFASHRM, CPPS: I think right now, what we're hearing in healthcare are a lot of positions being cut and programs being cut. You'll often hear that there's a freeze on hiring for any position that's not patient facing. These programs support those clinicians, though, and so I think that our health systems need to consider, are they eliminating or removing programs that would actually support the clinicians that are on the front lines of patient care. And so, you think about the training programs and nurse residency programs. Those are usually one of the programs that do get cut or understaffed and having those programs in place can help to decrease the likelihood of imposter syndrome from occurring. And so, I think our health systems really need to consider what they're cutting and what the impacts are on those who might be facing imposter syndrome.

Amori: So there's some financial implications as well. There's personal implications, recognizing it, there's educational implications, being aware of who those students are, and then there's the personal thing of being sure that the system is aware, right? That's good.

O'Sullivan: Exactly.

Amori: So as we close today's session, we're going to ask our traditional question of the one point we want our audience to take away for today, and this is it: How do we take care of or improve or work with imposter syndrome in healthcare to make it more beneficial and less detrimental? I guess I would like to start with you, Julie, if we could.

Samora: Sure. I think Dr. Drum did a great job in summarizing. Basically, leaders can help normalize imposter syndrome by demonstrating their own vulnerability, as he does with his trainees and his colleagues, sharing their own mistakes and their personal lessons learned throughout their careers. This normalization and sort of change in that culture can really minimize imposter syndrome for all and make a healthier environment.

Amori: Thank you. Thank you very much, Dr. Samora. Tatum?

O'Sullivan: I would say I probably have three points that I'd like to have as a takeaway, one being that healthcare systems need to put their money where their mouth is. Yes, the clinicians' positions need to be filled, but you also need people there to support them. You need the right people to help move the culture forward and make it safe to ask questions. And so, my second point would be that the leaders need to be tuned into this, and they need to create a culture where it's safe to say, "Hey, I have a question. I need more training. Not feeling great about my skill in this area."

Lastly, we need to keep having these conversations. And so I thank you and Med-IQ for having this discussion with us today. I think we need to keep normalizing that it's okay to be vulnerable and it's okay to question yourself.

Amori: Thank you, Tatum. Thank you. And Ben, what would be the one thing you would like our audience to know about imposter syndrome and what we need to do to address it?

Drum: Yeah, I have largely the same conclusion as the other two panelists. Share your imposter, be vulnerable, and just invite your imposter along with you when he or she is there, introduce him to your fellow colleagues, and really normalize what that looks like because that will make everything less scary, like I talked about earlier.

Amori: I wish every doctor in the United States could hear you. Thank you very much, all three of you. That was an amazing conversation. Thank you so much for joining us here today and sharing your wisdom, your humility, and your wishes for our providers and yourselves. And thank you to our audience for joining us here today. This has been a great conversation, and I'd like to thank you and tell you that we'll see you next time at *Perspectives 360*.