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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 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 the 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 the AON Global Risk Consulting Team, and the current president of the American Society of Healthcare Risk Management. Welcome, speakers, and welcome to our audience.

Today, we're talking about how imposter syndrome may present itself in any given healthcare clinician or student. In a previous podcast, we talked about the condition known as imposter syndrome that is rampant amongst many successful people in the world and especially among healthcare professionals. Some characteristics of imposter syndrome are the inability to accept, recognize, or internalize one's personal abilities and success, a discrepancy between one's own self-evaluations and the objective outcomes or evaluations of others, a fear of being revealed as a fraud, or a disappointment with one's current accomplishments, leading to endless driving for more.

The statistics on imposter syndrome indicate that women are more frequently affected than men, younger people more than older people, and physicians more than the general population. In fact, Shanafelt, et al., reported that nearly 1 in 4 physicians—actually, 23%—reported frequent or intense imposter syndrome. That's an earth-shaking statistic. That means that when I, as a patient, consult with the physician, they may not be feeling confident of their skills and knowledge. As a patient, I want that situation fixed. And since we also know imposter syndrome affects nurses, the majority of whom are women, as a woman, I want that fixed, too. Now we know that patients want their caregivers to be humble enough to admit genuine errors, but also confident enough to be able to make assessments, diagnosis, and move forward with treatment. We're going to ask our panelists what they believe is going on.

Julie, welcome back. Literature reveals that women are more likely than men to develop imposter syndrome. What is your perspective as a female orthopedic surgeon?

Julie Samora, MD, PhD: It's true. Women at all levels demonstrate less confidence than males, and this gender gap increases with increasing age. Interestingly, this lack of confidence or imposter syndrome does not correlate with any differences in true ability. For example, despite performing at an equal level to male medical students, female medical students consistently report more anxiety about their performance, greater stress over their competence, and less confidence in their abilities. Orthopedics is a very male-dominated specialty, with only 7% of women in the field. Challenges remain for women in a heavily male-based environment, given the prescriptive gender norms that form the

basis of some implicit bias in surgery. This type of environment could potentially exacerbate imposter syndrome for women and underrepresented minorities.

Amori: Wow. Okay. Ben, they've also said that a sense of tokenism has been linked to imposter syndrome—like, “I only got in because I'm a minority,” or “they had to accept X number of females, that's why I got in.” How do we work as an educator with students and residents to get them past that? They also had to have brains and interpersonal skills to get in, so how do we get them to believe that? Is that a cultural barrier, or are we somehow reinforcing the self-limiting beliefs?

Ben Drum, Md, PhD: Yeah, that's such a good and targeted and delicate question. I think a lot of how I conceptualize imposter syndrome is thinking about a lot of system issues and how different providers experience enacting healthcare. For example, I'm a White male, so when I walk into a room, I'm almost never confused to be the nurse or the janitor or the aide. But several of my colleagues—as a pediatrician, most are female—do regularly get mistaken for nurses and/or aides or janitors. And so, I think when you have patients mistaking you for not being what you are, I think also in terms of all of our implicit biases, it's likely that female physicians or physicians of color are likely questioned more by patients and probably from other providers, as well, in terms of their knowledge and their decision-making. And so there's kind of an affront that the system is telling them that you don't belong.

And so, there can be some personal things that we can do. And we'll talk about self-care and compassion and self-compassion and mentorship and things like that. But I want to be careful not to put the onus of correction on the person and say it's their fault, they need to figure out how to fit in. But rather, look at the system and say, we have an imposter system, and we need to fix that. And I think that's kind of where I would target that question is, what can we do as a healthcare system to make and promote inclusivity?

Amori: Okay. That's good. That's good. Tatum, imposter syndrome has been said to be the opposite of Dunning-Kruger effect. What is the Dunning-Kruger effect, and do you see any relationship?

Tatum O’Sullivan, RN, BSN, MHSA, CPHRM, DFASHRM, CPPS: So Dunning-Kruger effect is a bias that people have. Usually, this person has limited knowledge or competence in the field that they're practicing in, and they overestimate their abilities. And so, they walk into a room as a nurse, for example, and do a procedure that they've never done before, because they think, “I've got this. I know what I'm doing.” As a risk professional, I will tell you that often this is a very scary thing because you have an individual that could have or should have asked a question and been a little bit vulnerable, but instead, they had a lot of confidence in their abilities, and it didn't pan out well for themselves and sadly for the patient. I do consider it the exact opposite of imposter syndrome.

I will tell you also, in my experiences as a nurse and a risk professional, that I have heard several women say to me, “I feel like an imposter” because they've been given increased

responsibility or a leadership position or something of that nature. I always think, these are the individuals that have got it, that they were put in these positions for a very good reason. And then I look around at the people who don't have imposter syndrome, and think, what gives them this confidence when everyone else around them is questioning their abilities? And so, it's an interesting concept to think about, along with imposter syndrome.

Amori: And I guess I would further add, how do you suss out who has imposter syndrome and was willing to admit it versus those people who are acting like they have all kinds of confidence, who really don't, who really are scared to death and won't admit it? Those are the ones that scare me, frankly.

O'Sullivan: I agree 100%.

Amori: Yeah. You know, we always ask the question, if you had one thing for our audience to take away, and today it's spotting imposter syndrome and knowing what it is, both for the individual and for other people who work with them, let's say what that would be. What would you say, Ben? What's the one thing you want our audience to remember?

Drum: I would say that as healthcare professionals who know that imposter syndrome is common, we need to be thoughtful about the systems of medicine that are created and actively work to deconstruct the ones that aren't promoting inclusivity.

Amori: Okay, great. And Tatum, what would you say?

O'Sullivan: I would say, and I think Julie has said this before, that a little bit of imposter syndrome, a little bit of feeling like an imposter might be a good thing. It's okay to question your knowledge. It's okay to question your ability. That's how you move forward. That's how you learn things. That's how you become better at what you do. That would be my big takeaway, is that it's okay to be vulnerable, and it's okay to ask those questions because at the end, it's going to make you better at what you're doing.

Amori: Okay. So, Julie, how would you spot imposter syndrome? And let's say you have a colleague. What's the one thing you want our audience to take away from this? Like, how do we help people with how do you spot it?

Samora: We need to look for it. It's a hidden trait, and if we don't look for it, we can't minimize the effects. For example, in the surgical realm, if someone's volunteering to do, let's say, floor work or take on additional administrative responsibilities instead of being in the OR, which is what we are, we're surgeons, is it because they have feelings of incompetence or imposter syndrome? And if so, as leaders and as educators, it's our responsibility to work with them to build their confidence in order to achieve successes in the OR.

Amori: Okay. Wow. There's a lot of food for thought in all of this. So again, we're back to we need to help people. We need to allow them to be human and real in the healthcare system. This has been a really great conversation. I want to thank our panelists for their words of wisdom and our listening audience for being with us today. I hope our discussion has provided you with some new insights. And thanks again for joining us. We'll see you again next time in *Perspectives 360*.

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