Imposter Syndrome, or Not?

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Have you ever felt like you do not belong, and one day, someone will find out that you are a fraud? As a female orthopaedist, now chief resident, I feel this way at times. Patients often do not think I am the doctor, let alone their surgeon, even after I introduce myself as Dr. Imada, and staff often think I am a medical student. Recently, I was walking to the operating room and someone asked if I was lost. I know that I am not alone. I have come to realize that these imposter feelings fall into an "imposter phenomenon" that was first described in 1978, now known as imposter syndrome.[1]

Imposter phenomenon was first described by Clance and Imes in "high achieving women" in their case study of 150 successful women.[1] They often had symptoms of generalized anxiety, lack of self-confidence, depression, and frustration related to the inability to meet self-imposed standards of achievement. These women engaged in intellectual inauthenticity and flattery of others. They attributed their success to temporary causes such as luck, lack of effort, and easy tasks, while they attributed failure to lack of ability. They noted that repeated successes alone were not enough to break the cycle, and their proposed solutions included group therapy, keeping records of positive feedback, and psychotherapy. This was 44 years ago!

Imposter syndrome is not in the Diagnostic and Statistical Manual of Mental Disorders, so it is not a recognized psychiatric disorder. There are various imposter syndrome scales/surveys that have been validated, including the Clance Imposter Syndrome scale, which is often used in studies. A systematic review from 2020 noted that lay literature often uses the term imposter "syndrome," whereas medical literature more often uses "imposter phenomenon."[2] In this systematic review, the authors found 62 studies, all cross-sectional surveys, most of which had been published in the last six years of inclusion. Ethnic minorities do seem to suffer more from these feelings, and those who score higher on these scales (higher imposter feelings) have higher rates of depression and anxiety. Gender seemed to have a role, but 16 studies showed females are more affected than males, while 17 studies found no difference. Age may play a role, but studies were also conflicting. In one study, racial discrimination was found to lead to higher levels of imposter syndrome over time.[3]

What about imposter syndrome in physicians? One review showed that up to 70.0% of physicians had reported a sense of impostorism at some point in their careers.[4] Imposter syndrome is associated with increased rates of anxiety, depression, emotional exhaustion, depersonalization, suicide, and burnout. Bhama et al[5] found that 76.0% of general surgeon residents reported significant or severe imposter syndrome without any predictive characteristics. In orthopaedic surgery specifically, I only found one study of almost 300 attending and resident surgeons at one institution where women had higher levels of IS, more perfectionist traits, and less assertiveness.[6] They also found that imposter syndrome was less common with older age.

So, what can we do about it? The Ruth Jackson Orthopaedic Society hosted a webinar on imposter syndrome and perfectionism in surgical training, where I found some helpful takeaways: 1) finding and being a good mentor; 2) taking actionable steps to change our mentality of self-doubt; and 3) specific qualities that we, as leaders, can bring to the field to try to break this cycle, help build confidence in others, be confident and vulnerable when appropriate, and remove structural barriers to inclusion and belonging. Language is important, which was also touched on by Ruchika Tulshyan and Jodi-Ann Burey in their Harvard Business Review article about impostor syndrome.[7] We should avoid saying "winning" and "killing it" when talking about ourselves or others, be data driven in our evaluations and feedback so there is less unconscious or conscious bias, and set up accountability mechanisms for change. We should assess our organization's performance criteria and average time to promotion. We know the system was built on a foundation of bias, so those in charge should be transparent about their organization's locked doors and try to open and keep them open. I found one study that showed an inverse relationship between self-compassion and imposter syndrome.[8] So, self-compassion education may be protective. Through other avenues, I have also discovered that physician coaching can be helpful, as well as individual therapy and time.

I think one of the most important things we can do is to stop calling this a "syndrome." It is normal to doubt yourself sometimes, and its also healthy. Blind confidence is dangerous, especially in what we do as surgeons. But on the other end of the spectrum, paralyzing fear and self-doubt is also dangerous. Self-reflection and thinking about what is really meaningful in your life are

important. We should hold each other accountable while also asking for help when needed. Solidarity is important in the challenging job that we have, especially when we are sometimes questioned on a daily basis by patients and staff who think we are nurses or physical therapists. It is not right, but it happens to many of us. Normalizing it is not really the right word, but being able to talk and laugh about it is helpful.

I still have a lot of self-doubt, but I respect that it is healthy, and I think it makes me a better surgeon. We must get rid of this mask of doubt, because if we have these feelings, it is already there. Yes, the system is the problem. However, we are here now, so we need to talk about it now.

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