Commentary

Impostor in the Mirror: A Clinician's Reflection on Impostor Syndrome

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Imposter syndrome, the internalised fear of being exposed as inadequate despite evidence of competence, is common in medicine. Using personal reflections from early training and later leadership roles, this manuscript explores how postgraduate rotations, workplace hierarchies, and professional expectations foster self-doubt among clinicians. The emphasis on reflective practice, while central to professional development, can intensify self-criticism and reinforce feelings of inadequacy when combined with the cultural demand for perfection. Imposter syndrome should be recognised less as an individual failing and more as a systemic issue shaped by medical training and healthcare culture. Addressing it requires leadership that promotes psychological safety, meaningful mentorship, and supportive structures that balance humility with professional confidence.

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The memory remains distinct. As a newly qualified Foundation Year 1 doctor on a demanding medical ward, I was alerted by my bleep to a clinical query. An experienced nurse was requesting guidance regarding a deteriorating patient. In that moment, a profound sense of apprehension emerged, extending beyond mere clinical uncertainty. It was a deeper, more insidious feeling—an internal narrative suggesting I was a fraud, and that my incompetence would soon be exposed to my colleagues.

This phenomenon, which I would later come to understand as impostor syndrome, is defined as a persistent, internalised fear of being revealed as inadequate, despite objective evidence of one's competence [1]. It is particularly prevalent within medicine, a profession characterised by high stakes and immense pressure for perfection. My progression through postgraduate training, and subsequently into leadership roles, has necessitated a continuous negotiation with this internalised doubt. This journey has prompted me to question not only my own capabilities, but the very healthcare systems that appear to cultivate this pervasive sense of inadequacy among dedicated practitioners. This article is therefore not

an account of empirical research, but rather an interpretive, experience-based commentary on the systemic and cultural dimensions of this phenomenon within medicine. This exploration begins not with the individual, but with the very structure of medical education itself.

The rotational catalyst for insecurity

For resident doctors, the structure of postgraduate medical training can itself be a significant catalyst for impostor syndrome. The frequent rotation through new specialities and healthcare settings is presented as a pedagogical virtue—a method for gaining broad clinical exposure. While the educational intent is sound, the psychological impact can be substantial. Every few months, trainees are placed in unfamiliar environments with new colleagues, different hierarchies, and distinct local customs and processes. The process of building confidence, establishing trust, and forging professional relationships is perpetually reset. Each rotation can feel like a new beginning, requiring trainees to repeatedly demonstrate their competence. This constant state of being an outsider creates a fertile ground for self-doubt to flourish. This experience aligns with conceptual frameworks such as the 'hidden curriculum' in medical education—where unstated norms and structures teach valuable, and sometimes detrimental, lessons — [2] and the concept of 'communities of practice', where trainees may feel like perpetual peripheral participants rather than fully integrated members [3].

This experience highlights a critical misunderstanding of impostor syndrome, which is too often framed as a personal failing; a deficit of confidence to be overcome by the individual. This perspective is, however, incomplete. Impostor syndrome is not solely an individual pathology; it is a systemic issue. It can be understood as a rational response to an environment that, however unintentionally, fosters feelings of alienation. Effective supervisors and managers comprehend this dynamic. They recognise that their role extends beyond assessment to encompass robust support. They cultivate psychological safety, acknowledging that doctors in training are, by definition, learners. The expectation of infallibility is a counterproductive myth. True leadership involves creating systems with effective support mechanisms, which foster learning from error and value professional development over an illusion of innate perfection.

The dual nature of reflective practice

Beyond the logistical structures of training, the professional culture of medicine itself creates a unique set of pressures. The societal expectation for doctors to be perfect imposes a considerable professional

burden. Clinicians are expected to be paragons of knowledge, skill, and compassion; unwavering and flawless. This external pressure is amplified by an internal professional culture of intense scrutiny. From the earliest stages of medical education, the importance of reflective practice is emphasised. Regulatory bodies, such as the General Medical Council (GMC), have rightly embedded reflection into the core of professional development and revalidation [4]. Clinicians are encouraged to constantly analyse their performance, identify areas for development, and document their learning.

Ostensibly, this is a laudable principle. Humility and a commitment to lifelong learning are cornerstones of safe and effective medical practice. A practitioner who does not reflect is one who does not improve. However, this well-intentioned focus on self-critique can have unintended negative consequences. For individuals predisposed to self-doubt, the relentless requirement for reflection can transform into a state of hypercriticality [5]. It can feel like a mandate to focus disproportionately on mistakes, magnifying every minor error into a significant failure of competence. This triangulation of expectations; societal demand for perfection, professional requirements for reflective critique, and an intrinsic desire to provide excellent care, all create a potent environment for impostor syndrome to develop. The very tool designed for professional improvement can, paradoxically, reinforce a sense of inadequacy.

Balancing humility and professional confidence

This dynamic creates a constant tension at the heart of modern medical practice. How do we reconcile the necessary humility required for safe, patient-centred care with the professional confidence needed to make critical decisions under pressure? How can we foster a culture of continuous improvement without cultivating a cohort of clinicians inhibited by self-doubt?

The solution, I propose, lies in a more nuanced understanding of competence and a healthier professional relationship with uncertainty. It requires a challenge to the binary thinking that can dominate medical culture. As noted by Sacha Wright, two seemingly contradictory ideas can coexist [6]. It is possible to be a competent, skilled clinician who also experiences moments of uncertainty. It is possible to be confident in one's abilities while remaining humble enough to seek assistance and feedback.

The antithesis of impostor syndrome is not confidence, but rather a cavalier or arrogant attitude towards patient care. Most clinicians have encountered the archetype of overconfidence, where excessive self-assurance can lead to a disregard for risk and a dismissal of colleagues' concerns. This represents a far greater threat to patient safety than the conscientious doctor who re-verifies a prescription or seeks a

second opinion. Arrogance can precipitate error, whereas the humility that often accompanies impostor syndrome can be a powerful driver for diligence and safety. The objective, therefore, should not be to eradicate self-doubt entirely, but to develop strategies for its management—to acknowledge the internal critic without allowing it to undermine rational, evidence-based practice.

A systemic approach to a systemic problem

Reflecting on my early career experience in medicine, I recognise that the feeling of being a fraud was not a reflection of personal inadequacy, but a symptom of a system in need of reform. The solution to impostor syndrome is not to instruct individuals to 'be more confident'. It is to cultivate a culture that is more compassionate, supportive, and transparent about the realities of healthcare. This is not to say I have personally eradicated the impostor in myself, this sensation continues to ebb and flow in different components of my work and personal life. However, taking a step back and attributing a label to the sensation has been helpful to make sense of the feeling.

This requires a collective effort. For leaders and managers, it entails actively creating environments where vulnerability is not perceived as a weakness. It means providing meaningful mentorship and supervision that transcends formulaic portfolio requirements. It involves normalising discussions of self-doubt and celebrating the professional courage it takes to ask for help. For resident doctors, it means granting ourselves permission to be imperfect and recognising that a medical career is a long-term process of continuous learning.

The internalised 'impostor' will likely remain a feature of my professional consciousness. However, I have learned to reframe it not as an adversary but as a critical, if often uncomfortable, companion. We must not throw out reflective practice in the effort to tackle impostor syndrome, this is a key component of humility, personal inquiry, and reinforces a commitment to lifelong learning. The challenge for all of us in healthcare leadership is to create a system where this critical companion does not become a debilitating foe, for ourselves, and for the future generations of clinicians.

References

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