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LETTER TO THE EDITOR

Impostor Phenomenon: Issues of Timing and the Nuances of Identity

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We appreciate the article written by Gopal and colleagues entitled "Impostor Phenomenon Among Family Medicine Residency Program Directors: A CERA Study.[1]" Literature supports acknowledging and addressing impostor phenomenon (or syndrome) to help combat burnout and improve physician well-being.[2] The authors conclude that impostor phenomenon (IP) is not highly reported among program director (PD) respondents, even among those who identify as female or minorities underrepresented in medicine (URiM).[1] PDs are not a homogenous group, and we feel that highlighting two specific points relevant to this paper's findings is important.

IP is reported as widespread in medical schools, most notably among females and those students who are URiM.[3] Clance and Imes noted in their 1978 study a greater prevalence of feelings of impostor syndrome among women compared with men in general, without a similar correlation among business managers.[4] This finding begs the question of whether IP is a phase in the careers of high-achieving individuals, including physicians. Similarly, Gopal and colleagues stated, "IP may be a component of professional identity formation.[1]" Is there a developmental, natural, and necessary integration of one's identity that leads to a subsequent decrease in IP? Additional studies may elucidate whether and when IP eases during the maturation process of young physicians.

Indeed, if we consider IP as a phase in career development, then considering maladaptive versus adaptive strategies may be of interest. Prolonged IP creates a level of cognitive dissonance that may be unsustainable in those who choose to pursue academic medicine and eventually reach the level of a PD. For some, their professional identity is rife with isolation and alienation. Perhaps the isolation and alienation seen in females and URiM faculty are direct causes of the burnout, anxiety, depression, and low self-compassion they sometimes suffer, separate and distinct from the IP they confronted when first forming their professional identity.

Lastly, in this study, the sample size of non-White physicians was quite small compared to the White physician group. Moreover, the categorization of race as non-White when used in this study is nebulous. Every non-White race possesses different histories of marginalization in the United States. For example, Black or African American physicians inherit the history of government sanctioned Black suffering, racial violence, and nonconsented clinical trials such as the Tuskegee syphilis study. Asian and Asian American physicians are exotified and sometimes singled out as a model minority, which leads to isolation and alienation.[5] Stratified analysis of those PDs under the umbrella of non-White is necessary to determine who is experiencing IP and to what degree.

For these reasons, considering IP as a possible phase in professional identity formation is helpful, with the hope of identifying phases and the interplay among them. At the same time, devoting further research into IP of high-achieving physicians from many URiM groups would be prudent before we can more confidently make any definitive statements regarding their experiences.

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