

Evaluation Apprehension and Impression Management in Clinical Medical Education

William C. McGaghie, PhD

Abstract

Historically, clinical medical education has relied on subjective evaluations of students and residents to judge their clinical competence. The uncertainty associated with these subjective clinical evaluations has produced evaluation apprehension among learners and attempts to manage one's professional persona (impression management) among peers and supervisors. Such

behavior has been documented from antiquity through the Middle Ages to the present, including in two new qualitative studies in this issue of *Academic Medicine* on the social psychology of clinical medical education. New approaches to medical education, including competency-based education, mastery learning, and assessment methods that unite

evaluation and education, are slowly changing the culture of clinical medical education. The author of this Invited Commentary argues that this shift will bring greater transparency and accountability to clinical medical education and gradually reduce evaluation apprehension and the impression management motives it produces.

Editor's Note: This is an Invited Commentary on LaDonna KA, Ginsburg S, Watling C. "Rising to the level of your incompetence": What physicians' self-assessment of their performance reveals about the imposter syndrome in medicine. Acad Med. 2018;93:763–768; and Patel P, Martimianakis MA, Zilbert NR, et al. Fake it 'til you make it: Pressures to measure up in surgical training. Acad Med. 2018;93:769–774.

Two articles in this issue of *Academic Medicine* address the social psychology of clinical medical education. These articles are “Rising to the Level of Your Incompetence: What Physicians' Self-Assessment of Their Performance Reveals About the Imposter Syndrome in Medicine” by LaDonna and colleagues¹ and “Fake It 'Til You Make It: Pressures to Measure Up in Surgical Training” by Patel and colleagues.² Both studies used qualitative research methods to explore the social interactions that lie at the heart of clinical medical education, especially the ubiquity of evaluation

apprehension among doctors at all levels of training and experience. These articles teach us that much of everyday clinical education and learner evaluation is an intricate kabuki play involving a fear of failure, impression management, the importance of portraying an image of competence, face saving, the power of subjective evaluations, and the value of establishing and maintaining one's clinical reputation. Objective, reliable data have no role in these performances.

LaDonna and colleagues¹ invoked the imposter syndrome to explain why a small sample of Canadian doctors perceived that they were underperforming or failing clinically despite their strong credentials and positive peer feedback. The imposter syndrome, manifested as self-doubt, became prominent in clinical situations where self-confidence had to be expressed even when surety was absent. This phenomenon produced showmanship whereby “Performing confidently was perceived to be as, if not more, important than possessing actual medical knowledge or procedural skill.” Self-doubt and the showmanship it yielded were grounded in subjective impressions from the self and others about one's clinical fitness and how to respond in situations of uncertainty.

Patel and colleagues² amplified these findings in a surgical education context. Their goal was to “identify how general surgery residents perceived and performed impression management

during moments of patient care.” They found that fabricating stories, remaining silent, and avoiding calling for help were all behavioral strategies that general surgery residents used to convince their peers and supervisors that they were competent, confident, and decisive—that is, capable to meet or exceed perceived clinical expectations. Patel and colleagues wrote, “All participants suggested that the underlying motivation for impression management was to preemptively build a positive reputation to avoid being ‘branded’ with a negative reputation.” They added, “Participants felt that, through managing their impression, individual interactions with their superiors might translate into more positive evaluations, greater patient care responsibilities, and more freedom to learn and practice technical skills.”

The centrality of evaluation apprehension and impression management is not new in clinical medical education. Doctors in ancient Greece knew that their livelihood depended on a good reputation that needed constant cultivation via appearance, demeanor, and overt self-confidence. Historian P.K. Agarwalla³ wrote that, among Greek physicians in the fifth and fourth centuries BC, “the doctor was a showman whose craft not only involved healing the sick, but also defending his actions through pomp and circumstance.” He added that “[the treatise] *Decorum* stresses that the physician must ensure that the entire situation and patient is under his control lest he should suffer some

W.C. McGaghie is professor of medical education and professor of preventive medicine, Northwestern University Feinberg School of Medicine, Chicago, Illinois.

Correspondence should be addressed to William C. McGaghie, Northwestern University Feinberg School of Medicine, Department of Medical Education, McGaw Pavilion Suite 1-200, 240 E. Huron St., Chicago, IL 60611; telephone (312) 503-3884; e-mail: wcmc@northwestern.edu.

Acad Med. 2018;93:685–686.

First published online January 23, 2018
doi: 10.1097/ACM.0000000000002143

Copyright © 2018 by the Association of American Medical Colleges

criticism of his reputation. Furthermore, *Regimen in Acute Diseases* warns against erring while treating patients since this makes the physician ‘a laughing stock.’³ Evidence from 13th-century Italy shows that doctors in training at Bologna also routinely engaged in flattery and impression management to convince the faculty of their clinical fitness. In addition, fees, expensive presents, and lavish banquets were given to faculty at the time of students’ promotion to the rank of doctor as expressions of gratitude for teaching and mentoring.⁴

Contemporary scholarship about clinical medical education echoes these ageless findings that evaluation apprehension and impression management are key features of the student and resident experience in clinical medical education. Such works as the classic book *Boys in White: Student Culture in Medical School* by Becker and colleagues,⁵ *Becoming Professional* by Bucher and Stelling,⁶ *Forgive and Remember: Managing Medical Failure* by Bosk,⁷ and *Becoming Doctors: The Adoption of a Cloak of Competence* by Haas and Shaffir⁸ all have this consistent message. This body of work tells a uniform story that, beyond performance on standardized tests and board examinations, what really matters for success in clinical medical education is one’s self-confidence, reputation, and presenting the appearance of competence. For example, Becker and colleagues asked medical students, “Can you think of any particular thing about medical school that has been traumatic?” None of the students cited cadavers, autopsies, their first experience with death, or breaking bad news to patients in their response. Instead, “Fully three-fifths of the traumatic experiences reported [had] to do with situations in which the fear of making a bad impression on the faculty predominate[d].”⁵

Why have evaluation apprehension and impression management remained such prominent features of the clinical medical education culture from antiquity through the Middle Ages to the present? I believe that there are at least two reasons. The first reason is that no one doubts the

importance of professionalism, expressed as good manners, appropriate dress, discretion, poise, confidentiality, and psychological stability, as a key feature of a doctor’s character. In professional and public settings, a doctor’s persona is just as important as her knowledge base and skill set in portraying an image of competence.

The second reason concerns the slow and incremental acceptance of advancements in educational measurement and medical education technology that have begun to emerge only since the mid-20th century. Examples include the objective structured clinical examination, item response theory, problem-based learning, competency-based education, electronic portfolios, medical simulation technology, deliberate practice, and mastery learning. These and other innovations have allowed for the development and maintenance of medical learning environments that rely on rigorous, objective measures of clinical skill and knowledge acquisition; where subjective learner evaluations are acknowledged but not pivotal; where evaluation data are used as a tool for improvement, not as a weapon for punishment or humiliation; where evaluations of clinical competence are sought, not avoided; and where clinical showmanship takes a back seat to measured, sustained clinical competence acquisition and maintenance throughout one’s medical career. The use of such technologies and the culture they represent is beginning to overcome inertia and obsolescence in clinical medical education and to embed medical education in new, 21st-century thinking and practice.

Competency-based medical education,^{9,10} mastery learning,¹¹ and professional competence assessment methods that unite evaluation and education¹² are now gathering momentum to transform the focus of clinical medical education from theatrical displays to education for constant clinical improvement. I believe that evaluation apprehension will diminish slowly as a professional posture and impression management will decline

as an adaptive capacity, and that the medical profession will slowly embrace these new technologies, grounded in reliable measurement, feedback, and improvement, as a sound alternative to the increasingly obsolete status quo.

Acknowledgments: The author is grateful to Diane B. Wayne for critical comments about an earlier version of this article.

Funding/Support: None reported.

Other disclosures: None reported.

Ethical approval: Reported as not applicable.

References

- 1 LaDonna KA, Ginsburg S, Watling C. “Rising to the level of your incompetence”: What physicians’ self-assessment of their performance reveals about the imposter syndrome in medicine. *Acad Med.* 2018;93:763–768.
- 2 Patel P, Martimianakis MA, Zilbert NR, et al. Fake it ’til you make it: Pressures to measure up in surgical training. *Acad Med.* 2018;93:769–774.
- 3 Agarwalla PK. Training showmanship. Rhetoric in Greek medical education of the fifth and fourth centuries BC. In: Horstmanshoff M, ed. *Hippocrates and Medical Education*. Leiden, the Netherlands: Brill; 2010:73–86.
- 4 Puschmann T. *A History of Medical Education*. New York, NY: Hafner Publishing Co.; 1966. First published 1891.
- 5 Becker HS, Geer B, Hughes EC, Strauss A. *Boys in White: Student Culture in Medical School*. Chicago, IL: University of Chicago Press; 1961.
- 6 Bucher R, Stelling JG. *Becoming Professional*. Beverly Hills, CA: Sage Publications; 1977.
- 7 Bosk CL. *Forgive and Remember: Managing Medical Failure*. 2nd ed. Chicago, IL: University of Chicago Press; 2003.
- 8 Haas J, Shaffir W. *Becoming Doctors: The Adoption of a Cloak of Competence*. Greenwich, CT: JAI Press; 1987.
- 9 McGaghie WC, Miller GE, Sajid AW, Telder TV. *Competency-Based Curriculum Development on Medical Education*. Geneva, Switzerland: World Health Organization; 1978. Public health paper no. 68.
- 10 Powell DE, Carraccio C. Toward competency-based medical education. *N Engl J Med.* 2018;378:3–5.
- 11 McGaghie WC. Mastery learning: It is time for medical education to join the 21st century. *Acad Med.* 2015;90:1438–1441.
- 12 van der Vleuten CP, Schuwirth LW. Assessing professional competence: From methods to programmes. *Med Educ.* 2005;39:309–317.