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Navigating Personal Health Crises, Imposter Syndrome, Sexual Harassment, Clinical Mistakes, and Leadership Challenges: Lessons for Work-Life Wellness in Academic Medicine: Part 3 of 3

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Part 3: Non-Physician/Medical Education (Cases 13-18)

In this final manuscript of the three-part series, the authors address a range of professionalism issues of imposter syndrome, pregnancy and parental leave, second victim phenomenon, sexual harassment, response to a suicide, and managing a budget while advancing diversity, equity, and inclusion. The case scenarios have learners and non-clinicians as their main character, bringing attention to the challenges in effectively addressing the cross-cutting nature of the complex issues we see both in and around a career in medicine.

Case 13 (Author: Gaurava Agarwal, M.D.)

Medical Student: A 24-year-old male always had excelled academically and athletically. He graduated valedictorian of his high school class, magna cum laude from college, and performed very well on the MCAT examination. He played NCAA Division 1 football and continued to play in local intramural leagues for graduate students. He performed well in school and had a long-term relationship with his girlfriend whom he was planning to propose marriage. Despite the appearance of being incredibly successful, he struggled with feeling discontent and had a significant fear of failure.

Contextual Features: His father was a CEO of a Fortune 500 company, and his mother was an award-winning children's book author.

Solutions/Suggestions for Handling the Current Crisis: Imposter phenomenon (IP) refers to feelings of inadequacy and self-doubt due to an inability to internalize evident success and skill. Instead, individuals with high IP, tend to attribute success to external causes such as luck, needing to work harder than others, a mistake, fortuitous timing, or knowing the right individuals. They also have a feeling that they have tricked others into believing they are more capable than they really are.[1-4] There has been ongoing interest in IP because of the correlations to personal and professional outcomes including limiting career potential, worsening well-being, lower self-esteem, anxiety, depression, and lower job satisfaction.[5]

IP is measured most frequently using the Clance Impostor Phenomenon Scale (CIPS) named after the researcher who first described the phenomena in detail.[1,3,5] The prevalence of IP in medical students showed rates ranging from 22% to 60%. Transition periods are high risk times as there is a gap between what learners know and what they need to know, thus medical training may be a particularly fertile time for IP to flare.[3] While initially thought to be more prevalent in women, a growing body of literature suggests IP is common in both men and women. There is thought to be a connection between IP and individuals with high achieving parents. This could be due to the sense that one's success is due to their parents' connections and privileges rather than one's own merit, or that one is valued only by their parents for high achievement.[4]

The manifestations of IP can have some interesting paradoxes. People most often think that it represents a fear of failure, but it actually often entails a fear of both success and failure.[4,5] People have the fear of failure due to the self-doubt they experience about their actual abilities. In addition, when self-worth is derived from achievement of a task that often is not completely in one's control, anxiety can occur. However, people with IP also experienced fear of success because any additional successes likely will lead to additional pressure from the increased opportunities and expectations that will follow their success. People also reported procrastination due to fear of failure, workaholism due to the impostor feelings that compel them to work harder than others, and maladaptive perfectionism.

IP within medicine should be addressed both individually and systematically.[3] The first step in improving anything is recognition and awareness. Measurement scales such as the CIPS can be used to self-assess if, and how significantly, IP may be impacting someone's wellbeing. Individual strategies can include collecting feedback from trusted mentors and advisors about one's actual abilities and strengths.

One also can collect evidence about past accomplishments and evaluate how the accomplishments were achieved. Addressing cognitive distortions that foster IP such as catastrophizing can be helpful. Therapy, counseling, and coaching can help deal with IP and some of its associated comorbidities such as perfectionism, procrastination, anxiety, and depression.[3,5]

Given the high prevalence in medical training, programs should introduce the concept of IP to trainees proactively. Workshops can facilitate reflection and provide a safe space where trainees can recognize they are not alone in experiencing IP. Mentorship and coaching programs can help people be on the lookout for behaviors such as procrastination, avoidance, perfectionism, and poor work-life integration that suggest IP may be present. Fostering a culture that does not punish mistakes and instead provides effective feedback can create a growth mindset culture. Also, increasing praise for effort and process rather than achievement and outcome can normalize failure appropriately. For example, having meetings where people are praised for applying for a grant and not just receiving one can lead to reinforcing the importance of taking risks and trying to challenge oneself.

Personal Health and Well-Being during Pregnancy

Case 14 (Authors: Kimberly Chernoby, M.D., J.D., M.A., Julie Welch, M.D.)

Resident: A 29-year-old female surgical resident was 32 weeks pregnant. So far, she had no pregnancy complications; however, at a recent routine appointment, she mentioned to her obstetrician that she was noticing an increase in contractions and having a hard time staying well hydrated during long operating room (OR) cases. She was concerned about the demands of her call schedule and how her male colleagues will view her competency and professionalism if she cannot manage her demanding obligations. She was unsure of graduate medical education (GME) policies that address pregnancy and maternity leave and was worried about graduating on time.

Contextual Features: She has performed satisfactorily, but not exceptionally throughout her residency. Prior to this pregnancy, she miscarried twice. She was worried about the perception of asking for accommodations but also about the health of herself and her baby.

Solutions/Suggestions for Handling the Current Crisis: Accommodating personal health and well-being is critically important during residency training. Program directors should be knowledgeable about work-life policies and laws, while clearly communicating expectations with resident trainees to cultivate an environment of wellness around their personal and professional needs. There are several laws and policies that set the floor for the GME program's response to this case study involving a pregnant resident. While some policies may constrain the program's options, such as how much time off can be given without delaying graduation, other policies merely set the minimum requirements and the program may, and should, exceed those requirements.

The Pregnancy Discrimination Act is a federal law that requires employers to make the same reasonable accommodations for temporary disability that stems from pregnancy as they would for a temporary disability that stems from a cause other than pregnancy. The Equal Employment Opportunity Commission suggested that some temporary accommodations may be required for pregnancy including permission to sit or take water breaks or lifting restrictions.[6] In this case, the resident's GME program may consider accommodations such as providing the resident with a stool to sit during operative cases, allowing her to scrub out at regular intervals to take a water break, or changing her clinical rotation to one with shorter procedures or more time in outpatient clinic. Additionally, they may consider taking the resident off the overnight call schedule or 28-hour shifts during pregnancy given the evidence that these types of shifts increase pregnancy complications including preterm labor.[7-10] Beyond the federal requirements of the Pregnancy Discrimination Act, many states have laws that require workplace accommodations during pregnancy without regard to temporary disability status.[11] Reviewing and applying these laws and policy to support residency trainees should be a priority of all GME program directors to remove barriers and misperceptions and support resident's needs.

The amount of family leave (e.g., maternity or parental leave) the GME program provides the pregnant resident depends on a combination of federal and state laws, national Accreditation Council for Graduate Medical Education (ACGME) policy, board certification requirements, and hospital policy.[12,13] The Family and Medical Leave Act (FMLA) is a federal law that requires employers to provide twelve weeks (unpaid) leave to employees who have been employed for more than 12 months. Given this resident is not an intern, she would be eligible to take 12 weeks of FMLA leave.[14] The caveat is that this leave does not need to be paid, and the effect on graduation is determined by the national specialty board.

In July 2020, the American Board of Medical Specialties (ABMS) announced that all AMBS Member Boards would be required to allow residents a six-week period of parental, caregiver, or medical leave without requiring an extension in training, and without exhausting sick leave or pre-existing vacation.[15] Their motivation was to "offer residents and fellows more flexibility, reduce stress, and increase autonomy in making life decisions, especially with regard to family and parental leave".

Different specialty boards have responded to the AMBS Policy on Parental, Caregiver and Family Leave with different solutions. The relevant policy in this case is the American Board of Surgery's policy which allows four weeks of leave every academic year plus an additional two weeks off for parental leave once during the first three years of residency and once during the last two years of residency, for a total of six weeks of leave in a year without delaying graduation.[16] Whether this leave is paid is ultimately a decision made by the resident's hospital system, unless the state requires paid parental leave. Hospital policies on paid parental leave vary widely from no paid leave, paid leave in the amount of annual vacation with no additional paid parental leave, paid parental leave for a period of less than 12 weeks, or 12 weeks of paid parental leave.[17] Some hospitals also provide paid leave in the form of short-term disability. It is again important to remember that requirements to pay leave are a floor, and there is nothing prohibiting hospitals from paying for 12 weeks

of parental leave. In fact, the American Academy of Pediatrics recommends a minimum of twelve weeks of paid leave.[18] Some states require paid parental leave for state employees.[19,20]

As more women enter the physician workforce, pregnancy is becoming a routine event for GME programs. As seen in this case, the lack of standard policies to protect pregnant residents leaves the burden on the residents to ask for reasonable accommodations. Given the power differential and hierarchical nature of medical training, some pregnant residents may not feel comfortable asking for accommodations and can suffer harm to their pregnancy as a result. This partially may explain why women in medicine have twice the rate of miscarriages as the general public.[21] Instead, programs should adopt evidenced-based best practices such as eliminating night shifts and call during the first and third trimester to reduce the risk of harm to pregnant residents.[22] Additionally, GME programs should adopt 12 weeks of paid parental leave for all new parents as longer leave has been shown to improve both parent and infant health.[19] Finally, these policies should be made opt-out and communicated widely so that pregnant residents do not bear the burden of asking for accommodations and instead feel valued and supported. This approach serves to create a culture of wellness for residents by setting the expectation of flexible work-life policies that support them in achieving their professional and personal and family goals.

Case 15 (Author: Christine Hein, M.D.)

Fellow: A 31-year-old critical care fellow was in the final months of her training. In preparation for graduation, all senior critical care fellows take two months of junior attending call. She was called one night to care for a critically ill patient with severe pancreatitis. Ultimately, after several hours at the bedside, the patient acutely decompensated, had a cardiopulmonary arrest and died. Upon review of the case, it was discovered that the fellow missed the diagnosis of intra-abdominal hypertension which was believed by her attendings to be a proximate cause of death. She was devastated by her clinical mistake.

Contextual Features: The fellow felt guilty about the death of her patient, worried this case will result in a lawsuit, and was ashamed to have to face this as a new attending. She already had accepted a new job in another state, had her new medical license, and had been approved for credentialing.

Solutions/Suggestions for Handling the Current Situation: "There are two sets of victims after a system failure or human error has led to injury, and no one has done a good job of helping either. The first group of victims is patients and their families; the second is the health care workers involved in the incident.[23]

In November of 1999, the Institute for Healthcare Improvement released a seminal report, "To Err is Human; Building a Safer Health System", which sparked public awareness about medical errors and initiated a national discourse on the incidence of and reaction to medical errors.[24] Despite this landmark publication, a void persisted in the culture of medicine regarding coping with medical errors. Unrealistic standards of perfection are modeled during education and training, which are passed on to each new generation of physicians. This culture of infallibility directly opposes compassion and forgiveness for physicians and contributes to the shame physicians feel following an error. Healthcare organizations also exacerbate the impact of errors by failing to provide assistance, resources, or counseling for physicians, hampering the recovery from medical errors.

While patients and their families are the primary victims of medical errors, physicians and other members of the health care team are second victims. Second victim syndrome is defined as "those who suffer emotionally when the care they provide leads to patient harm".[25] It is recognized widely that medical errors have many negative consequences which lead to emotional and occupational distress for physicians. Physicians suffering from second victim syndrome experience guilt, shame, anxiety, and fear immediately after an error occurs. Without proper support longer-lasting reactions may develop, including decreased clinical confidence, burnout, post-traumatic stress disorder, and depression.[25,26]

After errors, physicians are commonly susceptible to feeling shame due to the medical culture of infallibility combined with personal characteristics of perfectionism. Shame has been correlated with negative coping strategies such as hiding and avoidance, which further can contribute to isolation and secrecy following a medical error.[27] A national survey of U.S. and Canadian physicians examined the impact of errors on various work and life domains.[28] After an error, physicians reported increased anxiety about future errors (61%), loss of confidence (44%), sleeping difficulties (42%), reduced job satisfaction (42%), fear of harm to their reputations (13%), and increased overall occupational stress (81%). A minority (10%) of survey respondents believed that their organization adequately supported them in coping with errors. Error severity and impact on patients, dissatisfaction with the process of error disclosure, and concern over future legal implications were all factors that influence the magnitude of distress physicians describe.

In the past two decades, much has been written about error disclosure in the medical profession. Once the exception, error disclosure is a foundational component of healthcare organizations' quality and safety programs. Apologies are a powerful tool in recovery from medical errors and benefit both patients and physicians in the error disclosure and healing process.[29] Apologies may restore trust in the physician-patient relationship, minimize the emotional impact, and facilitate recovery for both parties following an error.[30] In a 2007 study, 89% of physicians reported disclosing a medical error to patients, but only 18% had received formal training in this process.[28] While appropriate disclosure protocols are beyond the scope of this article, there is a clear need for specific training to ensure psychological safety for both the patient and the physician during error disclosure.

There is a growing body of evidence that has demonstrated an association between error disclosure and reduced litigation. Studies of patients pursuing litigation reported that many believed they would have been less likely to sue if they had received an apology.[31,32] The University of Michigan Health System reported that both the cost and frequency of litigation decreased in the five years following implementation of their formal error disclosure program.[33] As the culture

of medicine embraces error disclosure and apologizes as the evolving norm, many states are adopting "apology laws" that protect specific information shared in these conversations from being used in lawsuits against the physician.

In this scenario, the physician's guilt, shame, and anxiety should be addressed with a comprehensive approach. The healthcare system should offer support and counseling as needed. The physician should participate in the review process, error disclosure, and apology with organizational support, and contributing system factors should be identified and remedied. Throughout the process, the physician should be encouraged to focus on personal wellness concepts and positive coping strategies to minimize the impact of second victim syndrome.[34]

Case 16 (Authors: Tanya Anand, M.D., Bellal Joseph, M.D.)

Graduate Student: A 27-year-old female M.D./Ph.D. student had been working in the lab of a well-respected and well-funded researcher for the past seven months. Her work was exemplary, and she had made significant contributions to the lab. However, over the past three months, working towards a deadline for a national meeting and a grant application, the lab head asked all to work late into the evenings and on most weekends. On several occasions, the lab lead insisted the student complete additional tasks before leaving for the night, placing her in the position of being the last student in the lab with him. He repeatedly has initiated hugging and kissed her several times against her wishes. He insisted his advances are playful and harmless, but she felt uncomfortable and was unsure what to do.

Contextual Features: In high school, the student's parents divorced after her mother discovered her father's affair with his office administrator.

Solutions/Suggestions for Handling the Current Crisis: Late nights and multiple deadlines are common for an M.D./Ph.D. student. Training is extended. Additional years are spent learning important techniques and publishing new data with the purpose of creating a foundation for a research-oriented career focus. The goal is to establish one's own lab and perform independent research. Despite the hard work inherent in this path, there are troubling aspects in this scenario that must be addressed.

Several problematic issues existed. The first involved the expectation that all lab employees/students must work late in the evenings and on most weekends over the course of several months. Second, the lab lead singled out this student to stay and complete additional tasks before leaving for the night. Third, the sexual advances from the lab lead placed the student in the difficult position of refusing the unwanted attention from an individual supervising her.

The following paragraphs briefly discuss the dilemma and potential solutions for the lab employees and the M.D./Ph.D. student. Burnout is a notable concern for these students and employees. It is a state of mental and physical exhaustion related to work or care-giving activities.[35] As many as half of all U.S. medical students are affected by burnout with prevalence rates as high as 71%.

In this scenario, the long hours and weekend commitments were not sustainable for the well-being of the staff and allowed little time for recuperation. Useful strategies, such as restructuring the schedule and duties with the lab head to alternate tasks and weekends could be utilized. Strategy sessions with narrative appreciative inquiry methods detailing what works and expanding upon those practices may help as well.[36,37] In addition, incorporating wellness activities during the long days and weekends, such as group lunches, yoga, and time to attend to personal needs may allow for much needed breaks and promote improved mental health for the lab members.[38]

As to the vulnerability of the medical student and sexual harassment by the lab lead, unfortunately the circumstances are not unique to this student. In this lab, as in many areas of medicine, a dependent relationship exists between faculty and trainees. Faculty and department heads play a vital role in promoting trainees as they navigate academia. A detailed report published by The National Academies of Science, Engineering, and Medicine indicated that hierarchical and dependent relationships, isolating environs, and a male dominated environment such as those in academic medicine, create higher risk for the occurrence of sexual harassment.[39]

Current policies do not incentivize the prevention of sexual harassment.[39] For this student, the worrisome dilemma lies in the consequences to her future in the lab, her mental and physical well-being, as well as her safety, when refusing and reporting the lab lead's unwelcome advances. A written record should be kept of each occurrence. If possible, these incidents should be documented and discussed with the head researcher and the lab led to end the advances and the situations where the two individuals are alone together. Safe reporting channels exist in many medical schools, and these should be utilized to report the documented incidents at her school of medicine.[39] Examples include an ombudsman office on many campuses as a place to report sexual harassment confidentially. If she has an advisor, then this individual may be able to guide her through the reporting process as well. The expectation of bringing the incidents to light is that the student can work in a healthier environment that facilitates her continued growth and development.

Case 17 (Author: Donald Rosenstein, M.D.)

Medical School Dean's Office: A 42-year-old new Assistant Dean has been asked to coordinate a memorial service for a medical student who has died by suicide. He never had to address such a sensitive topic and was relatively new to his role and knew that he would be scrutinized for his management of this situation. Personally, he never struggled with mental health concerns and felt inadequate to lead this effort.

Contextual Features: The Assistant Dean recently moved from another state and was unfamiliar with the resources available at this new institution. He had a few contentious meetings with the Dean of the medical school and saw this situation as potentially leaving a devastating mark on his developing reputation at the school.

Solutions/Suggestions for Handling the Current Crisis: The death of a medical student from suicide was a tragedy for that student's family, friends, and larger health care community. As highlighted in the case, it also can precipitate a leadership crisis for the Dean's Office in the medical school. In this scenario, coordinating a memorial service for the student was assigned to a new Assistant Dean who felt "inadequate to

lead this effort". If the Assistant Dean were to mismanage this delicate task, it would reflect poorly on his leadership competence. Nonetheless, this moment was not about the Assistant Dean and his emerging reputation. Instead, his attention needed to remain focused on how to honor the student's life respectfully and serve the needs of the medical school. The history of contentious interactions between the Dean and Assistant Dean was relevant only to the extent that the Dean needed to be consulted and informed about planning the memorial service since the Assistant Dean worked for and represented both the Dean's office and the medical school.

Unfortunately, there was limited literature regarding suicide among medical students[40,41] and guidance for memorial services.[42] It may be helpful for the Assistant Dean to remember that the memorial service did not have to happen immediately. He can send out an announcement that there will be a memorial service and take the necessary time to plan the service carefully. Communications related to the student's death, and the medical school's response to it, should be crafted thoughtfully and reviewed with the Dean. With respect to the painful topic of suicide, language is critical. For anyone who has survived a loved one's death from suicide, the phrases "successful suicide" and "committed suicide" can be deeply hurtful and should be avoided.

The service should be viewed as one key component of a more comprehensive institutional response to this impactful event. Students should be reminded of existing mental health support services and wellness programs. Model programs to identify and intervene with medical students at risk for suicide are promising and suggest a need for wider implementation.[43] The aftermath of an event of this magnitude presents an opportunity to reflect on organizational changes that are needed to lessen the risks of future suicides among students.

There are several specific considerations that can help the Assistant Dean coordinate an appropriate memorial service. He needs to be actively engaged and attentive to process issues in planning the service (e.g., speaking with key stakeholders and communicating with the student's family, if they are willing and able, to learn about relevant familial and cultural customs and preferences). This is a leadership challenge. The Assistant Dean does not need to have professional or personal experience with mental illness, suicide, grief or mourning rituals. In fact, having the self-awareness that he feels inadequate in these matters can be turned into a strength; he should enlist a mental health professional and others to work closely with him to plan the memorial service.

A thoughtful and sensitive memorial service can help a community process a terrible event like a suicide. The Assistant Dean was asked to coordinate the service. He was not obligated to lead the entire service. After welcoming the attendees and providing brief introductory comments, he can turn over the proceedings to someone more comfortable with this role (e.g., a chaplain, a faculty member who knew the student well, or perhaps even the Dean). At a minimum, messages shared during the service should include the following: an acknowledgement of the magnitude of the loss for family, friends, and medical community (this should not in any way feel like a morbidity and mortality conference as it is not the place to explore precipitating causes for the suicide or the specific circumstances of this student's experience prior to death), and that help is available for all students who are suffering.

There may be understandable concerns on the part of the medical school's leadership about assigning blame, possible litigation, reputation damage to the institution, or fear of additional suicides. None of these concerns belong in the service. Instead, the faculty and leadership need to focus on the student who died and convey a genuine commitment to student health and well-being moving forward.

A student's death from suicide in any educational setting is profoundly unsettling. If carried out with compassion, humility, and authenticity, the response of administrators can make a major positive impact. If the new Assistant Dean can remember that no one manages a crisis like this by oneself, he can demonstrate effective leadership by enlisting the help and expertise necessary to honor the student and advance a culture of recognizing and responding to at-risk students.

Case 18 (Author: Sylk Sotto-Santiago, Ed.D., MBA, MPS)

Basic Science Faculty: A 52-year-old tenured professor of pharmacology had been informed that major budget cuts will be announced across the university. As such, faculty members had been asked to identify how to eliminate 10% of spending originating from departmental funds without disrupting the excellent research work. She was worried they will have to let staff members go, many of whom she has worked with for years. The university has been clear that decisions about staff must be made in alignment with the institution's commitment to diversity, equity, and inclusion (DEI). She was struggling to navigate the complexities of funding, research excellence, and honoring the years of dedication to the lab many made while being sensitive to the institution's and their personal commitment to DEI.

Contextual Features: Ten years prior, similar cuts were announced, and the department eliminated positions of three beloved staff members. She has felt guilty for that decision ever since.

Solutions/Suggestions for Handling the Current Crisis: The traditional basic scientists in academia support curiosity-driven research and a long-term vision of scientific progress.[44] Nearly half of basic scientists surveyed had been forced by economic pressures to abandon an area of investigation they thought "central to their lab's mission". More than three-quarters had been forced to trim back their recruitment of graduate students and research fellows. Nearly half were advising their students to seek careers outside academia. Clearly, the concerns and impact of budget cuts have potentially broader implications.

Because of this professor's previous experiences with similar cuts, a very intentional approach could be used this time. She should outline the problem with transparency and truthfulness, calling the research team together. There are many benefits of having diverse teams. Diverse teams are simply smarter. Diverse teams demonstrate the ability to digest information needed to make key decisions effectively and examine facts while remaining objective.[45] Inclusive teams make better business decisions two times faster with half the meeting time.[46] Well-functioning diverse teams value the ability to guide their approach and trust to solve problems when they know the ultimate outcome is a challenge. The team also may identify actions that would lead to the greater

good not only for the vitality of the team, but for the science performed, hence helping make tough decisions for themselves. With confidence in the team itself, the professor may allow for creative mechanisms to reduce expenses.

Some options may include supplemental federal grant funding, rebudgeting of grants, access to alternative funds, reallocation of funds, or reduced staff time. Conversations about individual team member career goals also are key in these instances and would help in facilitating transitions to graduate education, leadership roles, or opportunities to diversify and purse new research interests. In evaluating contributions to the science and team, this professor should keep equity in mind, especially making sure these professional individual assessments are free of implicit bias and prejudice impacting the perceived contributions of women and underrepresented groups in science, technology, engineering, mathematics, and medicine. If this professor has not done so, it is a good time to investigate equal pay for similar work, critical access to opportunities, and professional development. There are also additional options in utilizing the network of peers and colleagues available to this professor. With diversity in their own networks, she may identify key stakeholders and peers who have or are addressing similar circumstances.

Most importantly, diversity, equity, inclusion and excellence are not mutually exclusive. In fact, there is no conflict between them. This professor's course of action should take advantage of the diversity of the team and if it is not diverse, then it might be a time of reflection as to why that might be the case. Lastly, a DEI-case can be presented to the department chair driven by the importance of diversity as outlined by the institution's commitments.

REFERENCES

[1] Clance PR, Imes SA. The imposter phenomenon in high achieving women: Dynamics and therapeutic intervention. Psychotherapy (Chic) 1978; 15(3):241-247.
[2] Villwock JA, Sobin LB, Koester LA, Harris TM. Impostor syndrome and burnout among American medical students: A pilot study. Int J Med Educ 2016; 7:364-369. PMID: 27802178.
[3] Gottlieb M, Chung A, Battaglioli N, Sebok-Syer SS, Kalantari A. Impostor syndrome among physicians and physicians in training: A scoping review. Med Educ 2020; 54(2):116-124. PMID: 31692028.
[4] Kets de Vries MFR. The dangers of feeling like a fake. Harv Bus Rev 2005; 83(9):108-116, 159. PMID: 16171215.
[5] Thomas M, Bigatti S. Perfectionism, impostor phenomenon, and mental health in medicine: A literature review. Int J Med Educ 2020; 11:201-213. PMID: 32996466.
[6] U.S. Equal Employment Opportunity Commission. Enforcement Guidance on Pregnancy Discrimination and Related Issues. No. 915.003. June 25, 2015. https://www.eeoc.gov/laws/guidance/enforcement-guidance-pregnancy-discrimination-and-related-issues. Accessed June 19, 2021.
[7] Behbehani S, Tulandi T. Obstetrical complications in pregnant medical and surgical residents. J Obstet Gynaecol Can 2015; 37(1):25-31. PMID: 25764033.
[8] Cai C, Vandermere B, Khurana R, et al. The impact of occupational shift work and working hours during pregnancy on health outcomes: A systematic review and metanalysis. Am J Obstet Gynecol 2019; 221(6):563-576. PMID: 31276631.
[9] Stocker LJ, Macklon NS, Cheong YC, Bewley SJ. Influence of shift work on early reproductive outcomes: A systematic review and meta-analysis. Obstet Gynecol 2014; 124(1):99-110. PMID: 24901274.
[10] Fernandez RC, Marino JL, Varcoe TJ, et al. Fixed or rotating night shift work undertaken by women: Implications for fertility and miscarriage. Semin Reprod Med 2016; 34(2):74-82. PMID: 26854708.
[11] National Partnership for Women & Families. Reasonable Accommodations for Pregnancy Workers: State and Local Laws. September 2020. https://www.nationalpartnership.org/our-work/resources/economic-justice/pregnancy-discrimination/reasonable-accommodations-for-pregnant-workers-state-laws.pdf. Accessed June 20, 2021.
[12] Magudia K, Campbell SR, Rangel EL, et al. Medical specialty board parental, caregiver, and medical leave policy updates after 2021 American Board of Medical Specialties mandate. JAMA 2021; 326(18):1867-1870. PMID: 34751719.
[13] Tobin-Tyler E, Adashi EY. The ACGME's new Paid Family and Medical Leave Policy: Just the beginning. J Am Board Fam Med 2023; 36(1):190-192. PMID: 36759135.
[14] U.S. Department of Labor. Family and Medical Leave Act. https://www.dol.gov/agencies/whd/fmla. Accessed May 9, 2023.
[15] American Boards of Medical Specialties. ABMS Announces Progressive Leave Policy for Residents and Fellows. July 13, 2020. https://www.abms.org/news-events/abms-announces-progressive-leave-policy-for-residents-and-fellows/. Accessed June 20, 2021.
[16] The American Board of Surgery. Leave Policy- General Surgery. October 2019. https://www.absurgery.org/default.jsp?policygsleave. Accessed June 20, 2021
[17] Welch JL, Wiehe SE, Palmer-Smith V, Dankoski ME. Flexibility in faculty work-life policies at medical schools in the Big Ten conference. J Womens Health (Larchmt) 2011; 20(5):725-732. PMID: 21501084.
[18] Dodson N, Talib H. Paid parental leave for mothers and fathers can improve physician wellness. July 1, 2020. https://www.aappublications.org/news/2020/07/01/wellness070120. Accessed June 21, 2021.
[19] Burtle A, Bezruchka S. Population health and paid parental leave: What the United States can learn from two decades of research. Healthcare (Basel) 2016; 4(2):30. PMID: 27417618.
[20] Indiana Commission for Women. Paid Family Leave Reports. September 26, 2018. https://www.in.gov/icw/initiatives/paid-family-leave/. Accessed July 27, 2021.
[21] Khan A, Purakal J. The Misculture of Miscarriage. February 11, 2020. https://feminem.org/2020/02/11/the-misculture-of-miscarriage/. Accessed June 20, 2021.
[22] Chernoby K, Pettit K, Jansen J, Welch JL. Flexible scheduling policy for pregnancy and new parent residents: A descriptive pilot study. AEM Educ Train 2020; 5(2):e10504. PMID: 33898908.
[23] Wears RL, Janiak B, Moorhead JC, et al. Human error in medicine. Promises and pitfalls, part 1. Ann Emerg Med 2000; 36(1):58-60. PMID: 10874237.
[24] Institute of Medicine (US) Committee on Quality of Health Care in America. To Err is Human: Building a Safer Health System. Washington, DC: National Academies Press (US), 2000.
[25] Wu AW. Medical error: The second victim. The doctor who makes the mistake needs help too. BMJ 2000; 320(7237):726-727. PMID: 10720336.
[26] Christensen JF, Levinson W, Dunn PM. The heart of darkness: The impact of perceived mistakes on physicians. J Gen Intern Med 1992; 7(4):424-431. PMID: 1506949.
[27] Robinson JJ, Long B. Medicine's shame problem. J Emerg Med 2019; 57(3):329-338. PMID: 31431319.
[28] Waterman AD, Garbutt J, Hazel E, et al. The emotional impact of medical errors on practicing physicians in the United States and Canada. Jt Comm J Qual Patient Saf 2007; 33(8):467-476. PMID: 17724943.
[29] Gallagher TH, Waterman AD, Ebers AG, Fraser VJ, Levinson W. Patients' and physicians' attitudes regarding the disclosure of medical errors. JAMA 2003; 289(8):1001-1007. PMID: 12597752.
[30] Kaldjian LC. Communication about medical errors. Patient Educ Couns 2021; 104(5):989-993. PMID: 33280965.
[31] Hickson GB, Clayton EW, Githens PB, Sloan FA. Factors that prompted families to file medical malpractice claims following perinatal injuries. JAMA 1992; 267(10):1359-1363. PMID: 1740858.
[32] Vincent C, Young M, Phillips A. Why do people sue doctors? A study of patients and relatives taking legal action. Lancet 1994; 343(8913):1609-1613. PMID: 7911925.
[33] Gallagher TH, Studdert D, Levinson W. Disclosing harmful medical errors to patients. New Engl J Med 2007; 356(26);2713-2719. PMID: 17596606.

[34] Robertson JJ, Long B. Suffering in silence: Medical error and its impact on health care providers. J Emerg Med 2018; 54(4):402-409. PMID: 29366616.
[35] Ishak W, Nikravesh R, Lederer S, Perry R, Ogunyemi D, Bernstein C. Burnout in medical students: A systematic review. Clin Teach 2013; 10(4):242-245. PMID: 23834570.
[36] Gergen MM, Gergen KJ. Barrett F. Appreciative Inquiry as Dialogue: Generative and Transformative. In: Cooperrider DL, Avital M (Eds.). Constructive Discourse and Human Organization. Volume 1. Bingley, UK: Emerald Group Publishing Limited, 2004, pp. 3-27. ISBN: 9780762308927.
[37] Ridley-Duff RJ, Duncan G. What is critical appreciation? Insights from studying the critical turn in appreciative inquiry. Hum Relat 2015; 68(10):1579-1599.
[38] Jennings ML. Medical student burnout: Interdisciplinary exploration and analysis. J Med Humanit 2009; 30(4):253-269. PMID: 19865808.
[39] Johnson PA, Widnall SE, Benya FF. Sexual Harassment of Women: Climate, Culture, and Consequences in Academic Science, Engineering, and Medicine. Washington DC: The National Academies Press, 2018. ISBN: 9780309470872.
[40] Blacker CJ, Lewis CP, Swintak CC, Bostwick JM, Rackley SJ. Medical student suicide rates: A systematic review of the historical and international literature. Acad Med 2019; 94(2):274-280. PMID: 30157089.
[41] Laitman BM, Muller D. Medical student deaths by suicide: The importance of transparency. Acad Med 2019; 94(4):466-468. PMID: 30379662.
[42] Wishart PM. Letting go of preconceptions: A novel approach to creating memorial services. Health Care Women Int 2006; 27(6):513-529. PMID: 16820354.
[43] Downs N, Feng W, Kirby B, et al. Listening to depression and suicide risk in medical students: The Healer Education Assessment and Referral (HEAR) Program. Acad Psychiatry 2014; 38(5):547-553.https://doi.org/10.1007/s40596-014-0115-x PMID: 24705825.
[44] Johnson D. With federal funding for science on the decline, what's the role of a profit motive in research? June 5, 2018. https://theconversation.com/with-federal-funding-for-science-on-the-decline-whats-the-role-of-a-profit-motive-in-research-93322. Accessed November 7, 2021.
[45] Rock D, Grant H. Why diverse teams are smarter. November 4, 2016. https://hbr.org/2016/11/why-diverse-teams-are-smarter. Accessed May 2, 2023.
[46] Larson E. New research: Diversity + Inclusion = Better Decision Making At Work. September 21, 2017. https://www.forbes.com/sites/eriklarson/2017/09/21/new-research-diversity-inclusion-better-decision-making-at-work/?sh=283509c64cbf. Accessed February 7, 2022.

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