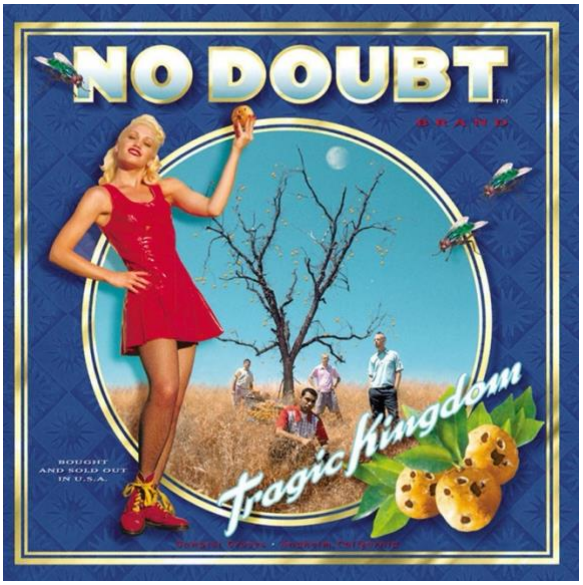
dear residents

Situational Doubt, Global Confidence **Dec. 7, 2025**

Dear Residents,

I recently came across a line in a novel by **Fredrik Backman** that stopped me in my tracks: *"Adults often think that self-confidence is something a child learns, but little kids are by their nature always invincible. It is self-doubt that is taught."* I found myself thinking about how true that feels in medicine. You do not arrive in residency empty of confidence or agency. You arrive curious, capable, and willing. But along the way, you are taught, sometimes explicitly and sometimes quietly, what to doubt.



https://www.udiscovermusic.com/stories/tragic-kingdom-no-doubt-album/

There is a form of doubt that is not only healthy but essential to being a good physician. This is the **situational doub**t we rely on every day: *Do I have the right diagnosis? Am I missing something? Is there a safer course of action?* This kind of doubt is the engine of clinical reasoning. It protects patients. It reflects humility in the face of uncertainty. It is not a weakness. It is a professional virtue.

But there is another kind of doubt that can take root during training, and it is very different. This is not doubt about a decision. It is **doubt about the self.** I *am not good at this. I do not belong here. Everyone else seems more capable than I am*. This is no longer a tool for thinking. It is an identity burden. And in a long, demanding training process, it can quietly accumulate.

It is worth acknowledging that medicine did not always talk about learning this way. **Not long ago, it was widely accepted, even expected, to be publicly yelled at on rounds**. Sometimes it was interpreted as a sign that the attending physician cared. It was uncomfortable, even humiliating at times, but many wore those moments as a badge of honor. Stories are still told, often fondly, of giants like **Dr. Seldin** and his sharp, unforgettable *"Here's a dime, call your mother and tell her that you are coming home."* There is no doubt that many of these legendary teachers cared deeply about their trainees and about their patients. They challenged fiercely because the stakes were high and because excellence mattered.

Years later, **Kim Scott** would give us the language of radical candor: **care personally, challenge directly.** In earlier eras, the challenge directly was unmistakable. What we understand far better now, however, is that without enough visible care personally, direct challenge can quietly slide from a correction of a decision into a verdict on a person. What was intended as rigor can be received as rejection. And in a deeply hierarchical system like medicine, repeated public correction does more than shape performance. It shapes identity. It sends signals, subtle and cumulative, about whose judgment is trusted and whose is not.

This is where the work of philosopher **Miranda Fricker** helped me think more clearly about what many trainees experience. Fricker describes something called testimonial injustice, the harm that occurs when someone's voice is given less weight **because of who they are rather than what they are saying**. Every day on our clinical teams, residents offer testimony: *I am worried about this patient. I think something is not right. I do not feel safe sending them home*. When those judgments are consistently doubted, overridden, or discounted beyond what the evidence warrants, the lesson learned is not just about medicine. It is about credibility. Over time, repeated credibility deficits can be internalized as global self-doubt.

We often label the psychological result of this as "impostor syndrome." And many of you have felt it, that persistent sense that at any moment you might be exposed as a fraud despite evidence of your competence. But I increasingly wonder if what we call impostor syndrome is sometimes less an internal flaw of the learner and more a rational response to environments that systematically question certain people more than others. In that sense, the issue is not simply how you think about yourself, but what the system has quietly taught you to doubt about yourself.

This is why the distinction between situational self-doubt and global self-doubt matters so much. Good training should multiply your capacity for the first while protecting you from the second. We want you to question diagnoses. We want you to pause before acting. We want you to ask for help early and often. But we never want a single missed lab, a delayed diagnosis, or a clumsy presentation to harden into a story about who you are as a physician.

I do not believe that the legends of prior generations set out to injure their trainees. I believe they cared in the language of their time. But our language of care is evolving. **We now understand far better that psychological safety is not the enemy of rigor.** It is the precondition for it. Today, we still challenge directly. We still name mistakes clearly. We still hold high standards. But we try to do so in ways that explicitly protect your sense of worth, belonging, and credibility as developing physicians.

If Backman is right, if self-doubt is taught, then we carry a profound responsibility for what kind of doubt we teach. **My hope is that in this program we continue to build a culture where questioning your clinical reasoning is a mark of wisdom but questioning your legitimacy as a physician is unnecessary**. Where uncertainty is welcomed as the raw material of learning, not mistaken for incompetence. Where your voice grows stronger over time, not quieter.

With respect and confidence in you,

Dino Kazi