CANADIAN MEDICAL EDUCATION JOURNAL | REVUE CANADIENNE DE L'ÉDUCATION MÉDICALE

2026; 17(1): https://doi.org/10.36834/hprhrb83

BRIEF REPORTS

As the lipstick rubs off: an autoethnography of impression management in a medical education conference

Beatrice TB Preti[1]

*Author information is provided in the back matter of this manuscript

Abstract

Impression management is the projection of attitudes, beliefs, or actions which are not wholly authentic, to influence perceptions of oneself. This paper describes an autoethnography, conducted in a medical education conference, detailing the process of impression management. The researcher is a PhD student and early-career clinician who wears multiple hats as a student, teacher, and researcher, allowing multiple viewpoints to play into the process of impression management. The autoethnography walks through a process of preparation, impression management, and authenticity which emerged during the observation period, ending with several takeaways to guide further research in this space.

Quand le rouge à lèvres s'efface : une autoethnographie de la gestion des impressions lors d'un congrès en éducation médicale

Résumé

La gestion des impressions consiste à projeter des attitudes, des croyances ou des actions qui ne sont pas entièrement authentiques afin d'influencer la perception que les autres ont de soi. Cet article présente une autoethnographie réalisée lors d'un congrès en éducation médicale, décrivant le processus de gestion des impressions. La chercheuse, doctorante et clinicienne en début de carrière, porte plusieurs « chapeaux » — étudiante, enseignante et chercheuse —, ce qui permet à différentes perspectives d'influencer ce processus. L'autoethnographie retrace un cheminement fait de préparation, de gestion des impressions et d'authenticité, tel qu'il s'est manifesté durant la période d'observation, et se conclut par plusieurs pistes de réflexion pour orienter de futures recherches dans ce domaine.

Background

Initially described by Goffman in 1956, impression management is a process likened to a theatrical performance, through which actors attempt to manage or manipulate the image or perceptions others have of them.[1] The original Goffman work cites medicine as a key field where impression management is observed; what doctors and nurses project to patients is not always what they feel or perceive behind the scenes. The discerning reader may note that such actions seem necessary at times in the provision of healthcare, and, indeed, impression management has become well-documented in both healthcare and medical education.[2] After all, physicians need to portray a certain level of competence and professionalism they may not always feel internally,[2] such as while running a resuscitation they believe will be unsuccessful, breaking bad news while grieving for a family member with the same condition, or rounding on the ward while hungry or tired post-call.

In medical education, trainees use impression management to appear in a more positive light.[3] This includes building positive reputations by projecting competence and confidence,[4] securing favourable evaluations by demonstrating mindsets perceived as desirable,[2] and gaining opportunities with desired faculty members.[3] However, impression management has also been shown to hinder learning, decrease trainee well-being, and negatively impact patient care.[3]

Energy put into impression management leaves less energy available to be channelled into other pursuits. Impression management can cause a strain on trainees struggling between being authentic and true to themselves, while simultaneously giving off an impression they feel will lead others to have favourable perceptions of them. Indeed, the question of authenticity versus impression management is one with historical roots and several implications in medical education,[4] necessitating further study to provide maximal support to trainees. While the process of impression management may consist of some level of authenticity (i.e., not be wholly inauthentic, or fabricated), parts of the truth may still be concealed by the actor, still leading to some of the sequelae associated with impression management.

Impression management and inauthenticity may very well have a role in medical education, encouraging professional behaviour and allowing trainees to "act" the part of physician until professional identity formation solidifies.[4] This is supported by my previous work, where I found that medical trainees use impression management heavily when applying for future training/positions, to maximise chances of success.[5] Medical educators (such as clinical faculty) also engage in impression management when interacting with trainees,[6] suggesting that impression management could be a reciprocal process.

Despite this current level of understanding, more work is needed to better understand the process of impression management and its impact on the individual engaging in the process. Given the self-centric nature of impression management, it is difficult to study through ethnography; however, interview-based methods looking at impression management rely on memory, which may not capture the process as a whole. Therefore, I conducted an autoethnography in a medical education space, to gain a closer look at the process of impression management and its impact on the practitioner. Specifically, this was my research question: how is impression management present in a medical education conference space?

Methods

I conducted and now present this study in accordance with the process laid out by Farrell et al.[7] For context, I am early-career physician one year into practice (at the time of the autoethnography), as well as a PhD student in health professions education. This affords both a student and consultant perspective. My clinical work and heavy involvement in medical education and medical education research allows for perspective into both the clinical and academic aspects of medical education. Personally, I am a mixed-race, mixed-religion cisgender female who, at the time of the conference, was the age of an average resident in Canada, and speaks with a somewhat Transatlantic accent. The venue selected

for the autoethnography was a medical education conference, with attendees from a variety of backgrounds and stages of career, some of whom were known to the attendee previously either through prior contact or exposure to the field, and others of whom were unknown.

This study was conducted using a relativist ontology (understanding impression management is a socially-constructed phenomenon), a subjectivist epistemology (knowledge is created through interaction), and a constructivist paradigm (understanding individuals construct their own understanding and experience of impression management).

Data were collected through field notes during conference activities; journal entries written at set times before, during, and after the conference; photographs with subsequent reflection; and texts, messages, and emails collected throughout the observation period. Debriefing and discussion with a senior mentor-colleague and a peer occurred throughout the observation period and analysis to improve reflexivity and awareness and was reflected in journal entries and text materials.

Analysis consisted of a content analysis performed[9] via descriptive and in-vivo coding,[8] and codes were subsequently combined into the narrative result presented as a product of this autoethnography.[7,9] An audit trail with notes was also kept during analysis to assist with reflexivity and awareness during the process.

This study was exempt from ethics approval as per the policies of the Western University Research and Ethics Board. Due to ethics constraints, texts, emails, messages, and any mention of or interaction with other individuals are not quoted in this manuscript. The results are presented in first person in the analytical-interpretive style,[9] to shed insight on a process of impression management in a medical education setting.

Results

As I prepared for the conference, I was cognizant of the multiple hats I wear: a teacher, a clinician, a student, a researcher, a lifelong learner. Having worked in the medical education space for a few years, I knew many of the participants from their work or prior conferences; I also knew quite a few participants from my time as a medical learner.

Multiplicity is challenging to navigate, and this time was no exception. As a new PhD student and early-career faculty, my goal at conferences was networking, building connections and learning about the work of others. Networking without impression management is seemingly impossible, as, by nature of the goal, one necessarily puts one's best foot forward. To add to the tension, I was also presenting the first medical education study I had personally led, which brought stakes as an early-career faculty hoping to gain traction in the medical education space. These goals contributed to pressure to perform and, weeks before the conference, I spent time carefully considering my outfits, shoes, jewellery, and makeup, trying to put together an outward picture of reliability, trustworthiness, and friendliness, even while I inwardly floundered and panicked. I also studied the conference attendee list, starting the networking (and the impression management) process days before the conference began:

> *I had to sort through who [I thought] would be appropriate to reach out to, and who wouldn't be likely to remember me, or whose name I had only read in a paper or online…some people I had to think carefully about whether to message… (Journal Entry #1)*

Impression management was carefully cultivated, both on the physical side and the action side, as I tried to project the image that I felt would be most likely to assist with my goals. Preparation continued upon arrival at the conference venue, where I rehearsed my talk several times on the conference computer system, also scoping out the presentation room beforehand to boost my comfort and confidence.

As time went on, I noted various ways I engaged impression management. In the beginning, a great deal of my impression management focused on physical appearance (perhaps, in retrospect, one of the easiest aspects to control, as well as one of the

easiest to judge), even after the conference had started.

> *My tights have a different pattern @ feet, I didn't notice, it looks bad. (Field Note #2)*

Lapses in impression management led to concerns about the projected image, leading to self-conscious insecurity. Impression management also spilled over into actions and conversations with others. In field notes and journal entries, I debated and reflected on several conversations–particularly ones ending prematurely or on a negative note.

> *It is a curious thing, to see people one knows, or one barely knows, and fret over in one's head, how one should act, what one should do. (Journal Entry #3)*

Impression management on all fronts was intended to promote the network-worthy front, the picture of reliability, responsibility, and approachability cultivated during the preparation phase. For me, the process of impression management started as an internal one, which was considered, then translated into outward actions.

My capacity for impression management fluctuated as the conference progressed. Impression management required energy, and the degree with which I was able to recruit impression management techniques was inversely proportional to the degree of exhaustion I felt.

> *As the time passes, I get more tired & focus on [impression management] decreases w/ my ability to care…b/c I am just too tired to do a good job @ this point. (Field Note #5)*

> *Torn in a session between speaking to the presenter, versus sending an email afterwards. Sometimes time influences, sometimes it's a split-second judgement of how I feel, how well I think I can present myself, or whether I need time to reflect and formulate a proper thought. (Photo Reflection #9)*

Throughout my engagement with impression management, there was a clear spillover of medical culture and hierarchy. As a clinician only just out of medical training, I am familiar with (and indoctrinated in?) both; as an academic and a student, I can call out factors and facets in more accurate terminology. As one might expect from a trainee, impression management was almost instinctual for me towards those perceived (or previously seen) as higher on the hierarchy ladder.

> *…still lingers in 'hierarchy', [major] speakers hard to approach (Field Note #6)*

As time passed, however, impression management fell to the wayside as I relaxed into authenticity. In moments of genuine curiosity or excitement, impression management was forgotten altogether.

> *Yet, I like to sit in the front row -- why? Why no concern over [impression management] ⟶ or does it not matter? Can I play the role of "audience member" so well that I am no longer concerned about impression? Or is it due to a genuine interest, so I don't feel managing the impression is necessary? (Field Note #4)*

This authenticity was found to foster feelings of connection and engagement. At times, conflict between authenticity and impression management was noted, with impression management (physical and action-based) usually engaged, despite knowing authenticity would win in the end.

> *One puts on lipstick, knowing it will rub off anyway. Yet one still does it. (Photo Reflection #10, see Figure 1)*

For me, authenticity shone through as humour, light-heartedness, genuine interest, and confidence; impression management was repeatedly associated with anxiety, exhaustion, insecurity, and discomfort.

> *I am just too tired to do a good job @ this point. (Field Note #5)*

Interestingly, and despite the lack of self-centred imposition in the research question, impression management of others was noted only at times, but only at times when there appeared to be a lapse in the impression attempts.

Figure 1. "As the Lipstick Rubs Off"

Discussion

I have documented here my experiences with impression management as a simultaneous student and teacher at a recent medical education conference. Impression management is slowly gaining attention in the medical education literature, but the process itself remains challenging to capture organically. This led me to pursue an autoethnography as the first step in gaining a better understanding of the impression management process in medical education.

During the observation period, impression management did follow an identifiable pattern (preparation, impression management, authenticity), a process which merits further study in the medical education space. Trainees have been shown to engage in preparatory behaviours for impression management, at times rehearsing[5] or, in the very least, consciously deciding on an impression to present.[10]

Impression management itself was noted during the autoethnography to require high levels of effort which could not be sustained for long periods of time. Although this will be a personal balance (certainly, personally, I tend towards having a low ceiling for high-stakes/high-effort interpersonal activities!), the toll of impression management on the practitioner cannot be ignored.[11,12] In the relative safety of a medical education conference space (when compared to the higher-stakes environments of patient care and clinical learning), impression management fatigue relaxed into authenticity and genuine interest. This may have a parallel in clinical and classroom medical education spaces; however, further work will also be needed to study this. That said, in a clinical environment, impression management may be necessary in patient-facing roles, which may siphon energy for impression management on the education side–or even education in general. This in itself may be sufficient to have dedicate curricular and teaching time on the topic.

In this autoethnography, impression management could be seen as a mask donned, whereas authenticity was the true face seen beneath when the mask fell off. The question arises of how an individual determines when impression management is necessary, or even desirable, and whether it helps to create the desired response in others, also merits further study. Interestingly, in this autoethnography, the highest levels of connection with and interest in others were associated with periods of authenticity.

Far less prominent, but still present in the data, was mention of the impression management of others. At several points during the conference, there were instances of recognition of failed impression management by others; there was no mention or recognition of the impression management efforts of others in other cases. The focus on impression management was almost exclusively on impression management of the self – intriguing, as this was not, as mentioned, a predetermined focus.

Of course, impression management is intrinsic to giving a presentation at a conference, or, even, simply attending a conference. In addition to the original Goffman, this relates to several social psychology theories, including self-monitoring theory, where individuals alter their behaviour to fit their surroundings;[13] and self-perception theory, where individuals adjust their behaviours to fit what they perceive others might react well to.[14]

Along these lines, certainly the experience of impression management was impacted by my experience as an individual perceiving the need for impression management (so many facets of experience!). Although I enjoy speaking in public, I am not yet confident enough in my professional identity or roles to feel comfortable being completely authentic in my interactions and demeanour. A more experienced or confident individual may perceive less of a need for impression management, which may impact their overall impression management conducted. They may also have a different goal–rather than networking, they may seek to give guidance or find a mentee, which may also lend itself more to authenticity over impression management.

This study highlights impression management as an important facet of the medical education experience and learning environment not previously studied (or understood) in detail. Impression management is rampant in medical education, playing a role in assessment,[10] professional identity formation,[4] and more. However, impression management also has risks.

In this autoethnography, we can see the toll repeated recruitment of impression management had on the practitioner. We also see that impression management was not needed (or helpful?) in areas of genuine curiosity, enthusiasm, and, indeed, learning. Moments of true connection were facilitated with authenticity–not impression management. This study provides insight into the behind-the-scenes of impression management, facilitating further work in this area targeted at assisting learners. Importantly, it presents a candid discussion of the use and experience of impression management, addressing an "elephant in the room," and paving the way for more open discussions about impression management in medical education. Exploration of this phenomenon in other medical education spaces (classroom, clinical), and from multiple perspectives, will be important for gaining a more comprehensive understanding of impression management in medical education. Autoethnographic approaches, triangulated with research-participant constructed understandings, provide one way to understand impression management.

Author information:

1- Department of Haematology & Medical Oncology, Emory University, Georgia, USA

Correspondence to:

B Preti

email: bpreti@qmed.ca

Published ahead of issue:

Jul 25, 2025

Conflict of Interest:

The author has no conflicts of interest to disclose

Funding:

None

Edited by:

Adam Neufeld (section editor); Cindy Schmidt (senior section editor); Marcel D'Eon (editor-in-chief)

References:

1. Goffman, Erving. Presentation of self in everyday life. *Amer J Soc.* 1959;55.
2. McGaghie WC. Evaluation apprehension and impression management in clinical medical education. Vol. 93. *Acad Med.* 2018. https://doi.org/10.1097/ACM.0000000000002143
3. Patel P, Martimianakis MA, Zilbert NR, et al. Fake it 'til you make it: pressures to measure up in surgical training. *Acad Med.* 2018. https://doi.org/10.1097/ACM.0000000000002113
4. Veen M. Wrestling with (in)authenticity. Vol. 10. *Perspect Med Educ.* 2021. https://doi.org/10.1007/S40037-021-00656-X
5. Preti B, Mangel J, Wang P, Stein R, Sanatani M. "Playing the game": a phenomenological exploration of trainee experiences with a rank-based residency selection matching process. *ICRE.* Ottawa; 2024.
6. Ginsburg S, van der Vleuten C, Eva KW, Lingard L. Hedging to save face: a linguistic analysis of written comments on in-training evaluation reports. *Adv Health Sci Educ.* 2016;21(1). https://doi.org/10.1007/s10459-015-9622-0
7. Farrell L, Bourgeois-Law G, Regehr G, Ajjawi R. Autoethnography: introducing "I" into medical education research. *Med Educ.* 2015;49(10). https://doi.org/10.1111/medu.12761
8. Saldaña J. *The coding manual for qualitative researcher*s. 4th ed. SAGE; 2021.
9. Chang H. *Autoethnography as method (developing autoethnographic inquiry).* Left Coast Press. 2008.
10. Huffman BM, Hafferty FW, Bhagra A, et al. Resident impression management within feedback conversations: a qualitative study. *Med Educ.* 2021;55(2). https://doi.org/10.1111/medu.14360
11. Wang W, Zhou K, Yu Z, Li J. The cost of impression management to life satisfaction: Sense of control and loneliness as mediators. *Psychol Res Behav Manag.* 2020;13. https://doi.org/10.2147/PRBM.S238344
12. Ai W, Cunningham WA, Lai MC. Reconsidering autistic 'camouflaging' as transactional impression management. Vol. 26. *Trends Cogn Sci.* 2022. https://doi.org/10.1016/j.tics.2022.05.002
13. Snyder M. Self-monitoring of expressive behavior. *J Pers Soc Psychol.* 1974;30(4). https://doi.org/10.1037/h0037039
14. Bem DJ. Self-perception theory. *Adv Exp Soc Psychol.* 1972;6(C). https://doi.org/10.1016/S0065-2601(08)60024-6