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Coping with Medical School: An Interpretive Phenomenological Study

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Abstract

Anecdotal evidence suggested that hopelessness and helplessness (HH) were often reported by undergraduate medical students. It is known that medical students are more susceptible to high levels of stress and depression than other student groups. There is currently concern about suicide rates in students and high drop-out rates in junior doctors. But what can be said of HH within this population? This study was aimed at eliciting medical students' experiences of HH. An interpretive phenomenological approach was adopted. Participants were recruited from a single medical school. Loosely structured, audio-recorded interviews were carried out. Recordings were then transcribed verbatim, then underwent an interpretive phenomenological analysis. Three participants were recruited. Their stories report some devastating experiences – ranging from social isolation to homelessness and suicidal ideation. Our cases complement the existing literature. Awareness of the issues raised in these cases may help medical educators to better understand and support others in similar situations. These may also benefit those experiencing HH themselves. We hope that this exploratory project paves the way to further study.

Keywords

medical students, medical education, hopelessness, helplessness, depression, coping, support, interpretive phenomenology

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Coping with Medical School: An Interpretive Phenomenological Study

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Anecdotal evidence suggested that hopelessness and helplessness (HH) were often reported by undergraduate medical students. It is known that medical students are more susceptible to high levels of stress and depression than other student groups. There is currently concern about suicide rates in students and high drop-out rates in junior doctors. But what can be said of HH within this population? This study was aimed at eliciting medical students' experiences of HH. An interpretive phenomenological approach was adopted. Participants were recruited from a single medical school. Loosely structured, audio-recorded interviews were carried out. Recordings were then transcribed verbatim, then underwent an interpretive phenomenological analysis. Three participants were recruited. Their stories report some devastating experiences – ranging from social isolation to homelessness and suicidal ideation. Our cases complement the existing literature. Awareness of the issues raised in these cases may help medical educators to better understand and support others in similar situations. These may also benefit those experiencing HH themselves. We hope that this exploratory project paves the way to further study.

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Introduction

Carl Jung talks about “Synchronicity” – a state in which circumstances and events are aligned in such a way as to make other events possible – in what he called “meaningful coincidences” (Jung, 1960). So it was for this project. John, a medical sociologist, has had a long interest in learned helplessness and was inspired by Martin Seligman’s work on it (Seligman, 1975; Gaber & Seligman, 1980) to begin his own research on the subject in 1982. Seb, as a master’s student, was, in turn, inspired by John’s teaching on a research methods course, and both had embarked on research using autoethnographic and phenomenological approaches to study the lived experiences of dyslexic medical students. Following on from this initial series of research, they continued to undertake wider research together. Anecdotal evidence, which Seb picked up during his time as a medical student, suggested that feelings of hopelessness and helplessness (HH) might be quite commonly experienced by medical students. Seb’s own previous experiences as a medical student gave him an insider view of the culture of medical school and some of the issues which this highly intense learning environment could create for students. As a medical student, Seb often felt both hopeless and helpless as a result of the highly demanding, stressful situation – as if he and others were stuck in a vicious circle of low grades and subsequent self-depreciation. Other medical students’ experiences suggested that there might be a hidden pool of HH in medical schools. The scene was set. So, when the opportunity arose for the two of us to work together again, Seb’s personal experiences and our mutual interests inspired us to conduct this study.

The concept of HH traces its roots back to the work of Overmier and Seligman (1967). Through a series of experiments studying classical conditioning in dogs, they theorised the concept of “learned helplessness” (Hahner, 1989). This refers to the mental state in which an individual does not try to improve or escape a situation, “because the past has taught them to be helpless” (Hahner, 1989). Seligman concluded that: (a) “helplessness saps the motivation to initiate responses,” (b) “helplessness disrupts the ability to learn” and, (c) “helplessness produces emotional disturbance.” That is, helplessness produces deficits in three major areas – motivational, cognitive, and emotional (Seligman 1975). In later work, Seligman refined this theory into the learned helplessness model of depression (Seligman, 1975). This refers to the stage in which helplessness has caused an individual to become depressed (Seligman, 1975).

Garber and Seligman (1980) discussed the impact that a perceived lack of control can have on the development of learned helplessness. They pointed out that one of the main determinants of the impact of learned helplessness upon an individual was the way in which that individual perceived and explained the situation – they introduced an “attributional” element to Seligman’s early model. Thus, the concepts of learned helplessness and its model of depression have been adapted through the years to realign with another theory – attribution theory (Hahner, 1989). Thereby, the development of learned helplessness may be explained through the ways in which people *attribute* the world around them. Attribution theory refers to the causality we individually assign situations that we encounter – the way that we view them (Davey, 2004). In her critique of the learned helplessness model of depression, Hahner (1989) explains thusly:

For example, is the attribution “internal” (the person is responsible) or “external” (person not responsible)? Also, is the attribution “global” (event seen as typical of life in general) or “specific” [only typical of events similar to this]?. ... in addition, depressed people will make more “stable” attributions, i.e., things are seen as always staying the same.

Therefore, one might say that a helpless, depressed individual typically attributes failures in an *internal*, *global*, and *stable* fashion (Metalsky et al., 1995). In other words, they see failure as their fault, long lasting and applying to all things they attempt. However, within this learned helplessness model of depression, each attributional dimension (e.g., “internal,” “global” or “specific”) is seen as playing a distinct, causative role (Metalsky et al., 1995). That is to say that an individual need not experience all three of those attributional dimensions in order to become depressed – one or two may be sufficient. This model of depression should, however, be regarded as distinct from the hopelessness model of depression. Within the hopelessness model, attributions are not seen as individual, causal factors of depression – that is, an internal, global, and stable combination (Metalsky et al., 1995). They are instead seen as a whole – a power of combined effect (Metalsky et al., 1995). Specifically, the “joint influence of making global and stable attributions” is required to make an individual “vulnerable” to depression within this model (Metalsky et al., 1995). “Consequently, unstable, global attributions for negative life stressors will not contribute to hopelessness or the hopelessness subtype of depression, nor will stable, specific attributions” (Metalsky et al., 1995). The hopelessness theory of depression also argues that internal attributions can be both positive and negative. When combined with unstable, specific attributions, it can be seen as “adaptive” (Metalsky et al., 1995). That is to say that, in this circumstance, an internal attribution may spur positive change. However, this may not be the case when it is combined with stable, global attributions. In that circumstance, an internal attribution may cause low self-esteem and dependence to accompany the hopelessness (Metalsky et al., 1995).

A scoping review of the literature concerning HH in medical students found little research into the experiences of medical students with HH. What research there was seemed to confirm our beliefs that experiences of helplessness may be a vulnerability factor for students at medical school and that the stress of this might negatively impact on academic achievement (Shaikh et al., 2004). This was echoed by Chaput De Saintonge (1998) who concluded that students who attribute as helpless may perform worse in examinations. Enns et al. (2001) suggested that what they termed “maladaptive perfectionism,” was associated with neuroticism and “predictive of symptoms of depression and hopelessness...” (Enns et al., 2001). But some studies went further and found that hopelessness may be a predictor of suicidality in medical students (Liu et al., 2008; Tan et al., 2015).

Alexandrino-Silva et al. (2009) looked into hopelessness in different groups of healthcare students. They concluded that there were no differences in the prevalence of hopelessness between medical, nursing and pharmacy students, but that medical students may experience *more severe* hopelessness than the other healthcare students. This is supported by Fan et al. (2007), who found that the greater the socioeconomic status difference between their two parents, the more likely medical students are to experience hopelessness. Zheng et al. (2005) highlighted that students’ experiencing hopelessness were more likely to have less social support, have immature coping strategies and to report more frequent negative experiences. Pessar et al. (2008) found no significant difference between the prevalence of helplessness between male and female medical students in their American study.

Recent student suicides have awakened concerns about the welfare of students. Gishen (2019) stated: “while the scale of the issue is currently hard to quantify, the impact, precipitating factors, and potential solutions are difficult to address if we do not acknowledge the problem.” Heiman et al. (2019) point out that, in the US, “prevalence rates for depression among medical students are three times higher than the prevalence rates of depression in the general population.” In a recent review of the literature on suicidal ideation in medical students, Coentre and Góis (2018) cited many studies worldwide but they were unable to cite any UK-based studies. There is also concern about rising numbers of junior doctors leaving the National Health Service (NHS) (Wilson & Simpkin, 2019). This is something which Adam Kay graphically illustrated in his book *This is going to Hurt* (Kay, 2017), which was based on his own experiences as a junior doctor in the UK NHS. Recently when John went into a curio shop, the young man behind the counter said to him, “You look familiar.” When John said he taught postgraduate medical students, the man remembered that John had taught on a course he had attended, and that he had given up his job as a general practitioner because he “just couldn’t take the strain of it anymore” and so he had left medicine to open his curio shop and was now enjoying his new stress-free life. Such stories are becoming, sadly, more and more common.

One might hypothesise that the inescapable stress of medical school education might similarly impact on medical students’ motivation, ability to learn, and their mental state. That is, the unpredictability of medical education itself might play a role in the development of learned helplessness in medical students. Learned helplessness may therefore be an area of interest and importance for any involved in the supervision or support of medical students. Thus, our research question for this study was: “What are medical students’ experiences of coping with medical school—in particular, with HH?”

Introduction to the Authors

Seb is an honorary clinical lecturer in medical education at Brighton and Sussex Medical School in the UK. His areas of teaching focus on research methods (particularly qualitative research methods) and medical education. His research interests focus on diversity

in medical education and student support. He also works clinically as a doctor in the United Kingdom NHS.

John is a principal lecturer in the Department of Medical Education at Brighton and Sussex Medical School in the UK. He is a medical sociologist whose career over the past fifty years has been teaching and research with various medical schools. His research interests have included death and dying, cancer, communications, psycho-social aspects of health and illness, and medical education. For ten years he has led the research methods teaching on postgraduate medical courses at Brighton. He is also trained in, and practices transactional analysis psychotherapy.

Methods

Conceptualisation and Ethical Considerations

The initial idea for the project was conceptualised jointly between Seb and John. In the first instance, due to the sensitive nature of the study area, we approached our institution's student support department to informally review the project. They discussed the study idea internally and provided feedback on its early stages. Once the study proposal was fully refined, it was submitted to the Brighton and Sussex Medical School Research Governance and Ethics Committee – our Institutional Review Board. They granted full ethical and governance approval for us to undertake the study. One of their stipulations was that Seb did not conduct any interviews with students he knew.

Philosophy and Methodological Approach

This study adopted a qualitative, interpretive phenomenological approach (IPA). Phenomenology is the branch of qualitative research focusing upon the essence of the “lived experience,” as seen through the eyes of its participants (Mackey, 2005; Shaw & Anderson, 2018). This may set out to either describe these experiences, or to interpret them – through the interplay of participant experiences, and the researcher(s)' search for meaning in them (Lopez & Willis, 2004; Shaw & Anderson, 2018). This study adopted an interpretive approach. We studied the lived experiences of our participants, embracing Seb's insider experiences, rather than trying to bracket out prior beliefs and experiences and our knowledge and thoughts about the topic (Gray, 2014). We strived to access the distinct realities of our participants and to report these faithfully – adopting a subjective ontology (Liamputtong, 2013). This was in keeping with our own views on the nature of reality, which centre around an interpretivist paradigm. We believe that reality and people's perceptions of reality are both socially constructed and ever-changing.

Sampling

An opportunistic sampling method was used (Gray, 2014). Participants were recruited from a single medical school. An email was sent to all students asking interested individuals to make themselves known by responding to the email. These were then contacted, sent a participant information sheet, and interviews were arranged at mutually convenient times and places.

Data Gathering

The qualitative interview is generally considered the data gathering method of choice for phenomenologists (Shaw & Anderson, 2018). Interviews may be structured, semi-structured, loosely structured, or unstructured – presented here in descending order of level of structure (Britten, 2006; Shaw & Anderson, 2018). Structured interviews generate data in a form that is generally considered easiest to analyse but allow for no flexibility at the time of data gathering. Unstructured interviews, however, allow the most “on the ground” control over the flow and content – allowing the researcher to tailor the interview to the participant in front of them – but they also generate data that is more challenging to analyse. We chose to use loosely structured interviews to gather our data. We had general topic areas to be discussed (in any order), but no specific questions. We felt that the personal and sensitive nature of our study area required an interview type with a high level of flexibility, whilst still covering certain areas – allowing for emotional topics to be appropriately and compassionately explored.

Seb’s experiences and insights were used to generate our topic guide. This was then reviewed independently by both John and another medical student who had experienced HH. In doing this, we aimed to generate the most appropriate guide, within the time and financial constraints of the project. Areas covered were:

- Experiences of HH
- Examples
- Detail of nature and severity
- Impacts on studies, social life, self-esteem, etc.
- Sources of support
- Helpful things
- Advice to staff/professionals
- Advice to others

In order to maintain anonymity and to avoid role conflict the interviews were conducted by John, who does not teach undergraduates at the medical school. Each interview lasted around forty-five minutes to an hour and took place either within local medical school buildings or over the telephone. Informed consent was received and recorded by John at the start of each interview. Participants were encouraged to tell their own stories – to give their own accounts, in their own words and order.

Data Analysis

Audio-recordings were transcribed verbatim. Each transcript then underwent an interpretive phenomenological analysis (Pope et al., 2006). This was performed by Seb and verified by John. The verification included review of the initial transcripts. The analysis was undertaken based on the steps outlined by Pietkiewicz and Smith (2014). Firstly, Seb read through the transcripts and listened to the audio recordings several times to immerse himself in the data. Whilst doing this, he made handwritten notes on a case-by-case basis. He then read back through these notes and generated initial emergent themes. These emergent themes were then reviewed in order to identify analytic themes. John replicated this process for his verification. Any differences were discussed and resolved in an iterative manner.

Due to the low numbers, we chose to use a modified case study approach in presenting the data. We felt that this mirrored the IPA ideal of representing the lived experiences of our participants in as much detail and clarity as possible, to retain the power and influence that each may carry. Each participant was given a pseudonym.

Results: Participant Stories

Three participants from a single UK medical school were recruited into this study. Within this section we present their personal stories, alongside assigned pseudonyms, before later progressing onto our analytical theme clusters in the next section. In doing this, we aim to first humanise them, and to give voice to their individual struggles.

Participant 1–“Amy”

“I just wanted to do something to make myself better... I mean I just wanted to maybe go to sleep forever” (Amy).

Amy was an international medical student in her final year. When Amy first started at medical school, she was placed in a student residence with twelve other first-year “medics.” She found the move from home a difficult and lonely experience. She found the high academic demands overwhelming. This left her with little time to socialise. As time progressed, she felt increasingly “different” from her peers. She did not fit in. She felt that she was not as intelligent and did not have their confidence. This caused Amy to become increasingly shy and reclusive.

During her second year she had an experience with a tutor which caused her immense and lasting emotional upset and self-doubt.

Sometimes she said harsh things to me... For example: “Oh, I think you should be aware of yourself, that [you’re] not speaking up in the group.” [And it was not about] being able to express myself... Just saying like I don’t have enough knowledge to be in medical school... (Amy).

Amy was devastated by this. Not good enough! A failure! Letting her family down! Amy found herself drifting into the background, and her tutor began to pick on her, telling her in the group that she needed to speak up, that it reflected her lack of knowledge, and that she would not survive medical school. When Amy tried to explain herself, she was misunderstood and told to work on her weaknesses. She then began to believe that she was all of these things that had been implied. She felt that she could not change these things, as they must just be a problem with her – her “weaknesses.”

Participant 2 – “Jess”

“I was just an anonymous kind of unnamed person...immersed in my own kind of self-loathing and world-hating mind set” (Jess).

Jess entered medical school at the age of nineteen. She was in her final year at the time of this study. Jess always saw herself as a well-organised individual. Her life was under control and heading in all the right directions. On arrival at medical school, Jess moved into a student residence. She was housed with students from a variety of different courses. She was isolated from her medical classmates and had no peers to compare her work with. She entered into the university experience like her non-medic hall-mates. It was not until she began to fail that she realised that other “medics” were working harder than her.

Once she started to fall behind, she noticed herself losing control. This worried her. Jess struggled to keep up, and eventually had to repeat her first year. Whilst she was grateful for this opportunity, Jess found repeating the year such a negative experience that she tried to change course. The hardest consequence was watching her friends move on without her. They

progressed academically and socially. They were no longer her “friends.” She struggled to integrate into her new year. She had no friends and no support. From this point, things went downhill for Jess. The feeling of isolation led to her giving up emotionally. She no longer wanted to study medicine and, therefore, could not see the point in trying. Reflecting on this, Jess noted a strong mix of rebellion and apathy, which gave an illusion of “control.”

Jess was labelled as “different,” an “outsider,” someone who did not fit in. This was, however, trumped by other concerns—she needed a home. Jess had planned to move into a house with her old classmates, but they did not welcome her. Here, she made her first cry for help, asking her friends to support her in finding a guarantor in order to be able to rent a flat. They refused, leaving her with nowhere to live and a deeper sense of exclusion. She turned to her family, but they too rejected her. Jess survived by living with her new boyfriend. She had almost no possessions and his flatmates wanted her out – and this was in addition to the pressures of being a busy first-year medical student, again. She was diagnosed with depression and started on medication. Unfortunately, she then suffered with a common side effect of this—a loss of libido. This led to tensions with her boyfriend, who was her only source of personal support at the time.

Jess’ salvation came when she was moved back into halls of residence. At last, she had a stable home in which to work and recover. Whilst she had suffered ups and downs, she was now in a better place.

Participant 3 – “Ryan”

“More effort needs to be done to empower medical students to care for each other... Maybe it would have to be incorporated into the curriculum, or maybe foster a culture from [the] top down—from faculty onto students” (Ryan).

Ryan was a medical student, who had already completed a bachelor’s degree elsewhere. He was in his second year of medical school. As this was his second “first degree,” Ryan was not eligible for the student loans his peers received. He found himself beginning to struggle financially. Although anticipated, these challenges were far worse than imagined. He had five part-time jobs whilst being a busy medical student. He found no time to socialise and could not commit enough time to academic work. He felt that this adversely affected his grades.

He too, was “different.” He was older. He did not mix socially with classmates. He had constant money worries. He worked almost all his spare time. His life was a balance of earning money to survive and getting through his studies. He found life hard, but he did not let it get him down. Jobs might be precarious, but he believed he could do his paid work and study. He was prepared to do this, and he saw an end in sight—even though it was in the long term. Balancing the different demands on him was draining. But he was managing. There was an end in sight, eventually, and that made it worthwhile.

Results: Analytical Themes

Isolation and a Culture of Silence

Isolation proved to be a significant issue for all three of our participants. This sense of being alone fuelled their feelings of hopelessness and/or helplessness.

Amy was isolated both physically and socially. The physical distance from her family, combined with the stress of medical school appeared to be the beginning of her isolation. *“I wouldn’t say I talk to my parents about this because I don’t want them to worry” (Amy).* Her tutor’s comments singled her out as “not good enough” – different from the others. She

withdrew. *“Just not being used to the environment and not expecting...not knowing what to expect in medical school”* (Amy). This singling out led to her questioning the validity of her struggles. *“So that is when I thought maybe it is just me, it is just my problem”* (Amy). Subsequently, she questioned her own sense of worth as a medical student and began to feel increasingly isolated from her peers. *“I felt like I [was] dealing with the situation alone, by myself”* (Amy). These experiences made a sense of isolation into the reality of isolation. This became a self-fulfilling cycle based on a negative self-image, fuelled by doubt and fears about her own abilities and worthiness. She had no one to turn to for an appropriate source of reference – no one to compare herself with. She felt as though she did not fit in with her English peers. *“I tried to make friends with the local people but then it is not like you can ever blend in very well”* (Amy). She could also find no support in fellow international students. *“And I don’t have any other international students in the course. So I can’t really share like... the experience with them”* (Amy). This fed further into her state of isolation. *“I was trying to avoid going to meals, to the canteen together, when I lived in the university. I didn’t want to see anyone from my course at all.”* (Amy).

Repeating the first year left Jess feeling isolated and stranded in a cohort of unfamiliar faces. She had been abandoned by her old friends. *“I had a lot of friends... And then, you know, if I ever passed them in the corridor, I would just kind of get a sympathy nod, [with] ‘how is first year?’ ‘It is a shame isn’t it?’”* (Jess). She struggled to integrate into her new year. She had no friends and no support. From this point, things went further downhill for Jess. *“I would just sit by myself and kind of turn up late in hoody and joggers and sit at the back and leave early”* (Jess). The few new peers that she did talk to were not able to understand her, or what she was going to—she could not open up to them. *“I don’t think we talked about, you know, any real problems”* (Jess). Furthermore, the long hours of study required did not afford her time to process her own difficulties or to live her life.

Being in Med School kind of nine-to-three or nine-to-four every day doesn’t really give you time to sort out your own affairs. Especially as you are expected to come home and do another three hours of revision...it just felt like a lot. It felt like too much really” (Jess).

This all weighed down on her, causing her to feel like a failure – something that has persisted to this day. *“I still feel like a bit of a failure when I think back to that time”* (Jess). Her struggles went unnoticed amongst her peers, who labelled her rebellious attitudes as “cool” rather than seeing a vulnerable person in distress.

So, I didn’t talk to anyone in my old year. I didn’t talk to anyone in my new year. Since then, I have found out that everyone thought I was actually very cool by going in and sitting by myself. But it turns out that I was just like massively depressed (Jess).

Ryan reported a general culture of silence and avoidance of acknowledging such issues within medical school. This left him feeling isolated from his peers.

I would suggest there is a certain culture of maybe just “brush it under the carpet” and to kind of pretend things are ok [at medical school]...so, for students who are quite financially challenged like myself, I think it is difficult to speak quite openly about it... One of the issues, on top of the sense of isolation, is the inaccessibility to actually discuss the issue widely... (Ryan).

Culture Shock and a Lack of Control

Amy and Jess both described issues relating to a lack of control or an unfamiliarity with the new surroundings of medical school. These experiences fed into their senses of sorrow and, eventually, into the development of HH. Due to living with “non-medics” Jess drifted into a false sense of security, away from the competitive culture of medic life. Whilst this may have sheltered her transition into university, she feels that it was the root of her later problems. “*So, it was a bit of a shock when I came to medical school and found myself falling behind*” (Jess). This resulted in Jess losing her sense of control over her life and her surroundings. This lack of control over the world around her is something that Jess attributed directly to her experiences of HH. “*... A lot of changes all happening at once and again just not really feeling in control of anything*” (Jess). She discussed this frequently throughout the interview. Each time, she discussed different ways that she slipped into a lack of control and how this affected her.

Amy found herself missing her family back home. The intensity of the medical school workload combined with the unfamiliar culture in the UK proved challenging. “*I was not used to the culture here... Just not being used to the environment... I felt the pressure... [I felt] a bit homesick as well*” (Amy). This was compounded by the lack of other international students she could relate to. “*They don’t have enough international medical students*” (Amy). This led to Amy doubting herself and her choice to study medicine. “*I just keep thinking why I wanted to go to medical school... I was thinking shall I just carry on with this or shall I change into other courses, with less pressure and stuff*” (Amy).

Judgement, Rejection and Interactions With Others

Various root causes of Jess and Amy’s hopeless/helpless states seemed to stem from their interactions with others, be they peers or staff. Recall Amy’s aforementioned experience with one of her tutors:

Sometimes she said harsh things to me... For example: “Oh, I think you should be aware of yourself, that [you’re] not speaking up in the group.” [And it was not about] being able to express myself... Just saying like I don’t have enough knowledge to be in medical school... (Amy).

Amy found her tutor’s comments completely devastating. This led to her re-assessing her own sense of self-worth and academic abilities. Amy internalised this as a totally damning judgement of her. She felt completely destroyed intellectually and as a person. She felt that not only was she not adequate intellectually, but also was a failure as a person. “*What she said just kept echoing in my head. And I thought, oh, maybe I am really that kind of person and that is why I can’t change for it*” (Amy). We must remember that the important outcome in any educational encounter is the sense that the student makes of what they are told. Hence, Amy’s interpretation – that she was no good, would never become a doctor and was not worth her place in medical school – was crucial in determining the impact of what was said.

As a failing student, Jess was rejected by her initial classmates, and she did not fit in with her new classmates. “*I basically had every tie cut all at once*” (Jess). Repeating the year led to Jess losing her social identity. Everything that made her who she was had been left behind. She had been the popular girl, the party girl and the good friend. But what was she now? Her sense of self and her adopted role within the medical school had been taken from her. Her own sense of self did not match others’ image of her – “*everyone thought I was actually very cool*” (Jess) – which further enhanced her difference. Students in Jess’s new year saw an outsider who rejected the expected traits of a first-year student. She was labelled as

“different,” an “outsider,” someone who did not fit in. *“I was just an anonymous kind of unnamed person... immersed in my own kind of self-loathing and world-hating mind set”* (Jess). Her peers labelled her “cool” – oblivious to what she was really experiencing. No one recognised her suffering. She then grew to resent the new students. She did not want to be with them. She did not want to socialise. *“I was pretty resentful of all the very keen new students in my new first year. I was quite resentful towards all of them because I just didn’t want to be there”* (Jess). This resentment fuelled Jess’s later problems, as she reported a negative spiral of social isolation and apathy. *“I would just sit in lectures rolling cigarettes. And looking back at it, it is pretty stupid, but I didn’t really care at all what anyone thought”* (Jess).

Supports – Personal, Formal, and Desired

All three of our participants reflected on supports in their own ways. Sources of support were varied in both their type and effectiveness. Some even proved counterproductive and perhaps caused more harm than good.

Jess’s boyfriend’s flatmates resented her. *“I had moved in two days, and one of them sat me down saying: ‘You have overstayed your welcome’”* (Jess). Moving into the new house helped her immensely.

I think it all got better really when I moved into the new house ... So I had my own place to stay... And in fact, I think a couple of people from my old year, who were also resitting, would come home for lunch. So... I got to know some people... (Jess).

Whilst things had stabilised a little for her, Jess did not seek support from her medical student peers. *“I don’t think I turned to anyone in the medical school after I had been accepted back into the first year. I think that is when I stopped talking to anyone really”* (Jess). She did however make use of formal medical school support services that were offered. *“... I mean I found them (student support) really useful... I have probably used it much more as the counsellor sort of aspect.”* (Jess). Despite this, she still felt unable to make proper use of counselling services she was referred to. *“I felt quite embarrassed to be like whinging about a relationship or whinging about not studying hard enough”* (Jess). This mental juxtaposition was a dilemma for her. Subsequently, she agreed to a trial of antidepressant medication. However, this caused her significant issues in itself. *“It made me feel incredibly nauseous for a week and then just dulled every emotion that I had”* (Jess). That created a feeling of helplessness, compounded by a lack of consistency in the support provided by her primary care provider.

I had my GP (General Practitioner) who actually I didn’t know—it was the one on campus—so you just turn up and see a different nurse every time, and I don’t think I ever even saw a doctor once (Jess).

Classmates distanced themselves from Jess when she had to repeat the first year. They *“decided not to live with me because they couldn’t get a guarantor for the rent”* (Jess). Her parents “abandoned” her in the sense that they were not there for her, and she could not live with them. Her boyfriend supported her, but the side effects of the anti-depressant medication even threatened that source of support.

[The anti-depressants] almost killed my relationship because...it kind of disgusted me to think of [my boyfriend] holding my hand or trying to kiss me –

that physically repulsed me... When they say, “loss of libido is a side-effect,” it really is. You know, probably a lot worse than just that phrase (Jess).

Ryan’s issues stemmed from a lack of financial support during his studies. His inability to obtain student loans led to struggles for simple living expenses—food, rent, and bills, etc., alongside tuition fees. “... *This invariably means that you have to find about £9,000 a year to obviously fund your way through the course*” (Ryan). This lack of support forced him to spend the majority of his limited free time finding paid work. “*So, I do secondary school mentoring... A lot of Student Ambassador work... I work at two different GP surgeries as a note summariser... And then finally I work at a Jamaican takeaway...*” (Ryan). This made his life significantly more challenging than it needed to be and could potentially have jeopardised his attainment at medical school. “*The hardest parts have very much been the juggling of... time with managing finances*” (Ryan). In that sense, access to financial support would have made a big difference to Ryan’s experience of medical studies.

Amy’s experiences of supports were varied. The first problem was her sense of guilt and low self-esteem. To ask for help would confirm that she had a problem and would make others aware of it. She mentioned both formal medical school supports and the emotional support of friends. However, her friends were not able to understand her and were unable to empathise with what she was going through. She withdrew from them. She also could not turn to her family, because of her deep sense of guilt—she did not want them to think that she had let them down. “*I wasn’t able to find any help at all... From the medical school or from my friends or from my family. I felt like I [was] dealing with the situation alone, by myself*” (Amy). Consistent, formal supports might have allowed her to get back on track, without straying further from her cohort socially and academically.

Maybe (sigh) if they could have a personal tutor or a mentor or something, for overseas students that might be very helpful, rather than seeing different [people] at different times. So, you have to repeat the same thing again and again and again. And they could follow up you throughout the medical school (Amy).

Amy was aware of the student support department within the medical school but had no knowledge of other services available to her. “*I only know [the medical school] in the Uni. I didn’t get to know the other places in Uni*” (Amy). She knew nothing of the wider university, beyond the medical school. This was her world.

Self-Harm and Suicidal Ideation

During the interviews it became clear that suicide had been a real option for two of our participants – Amy and Jess. Both of their personal circumstances had led to states of hopelessness. They could see no light at the end of the tunnel that was their lives at medical school.

For the aforementioned reasons, Amy became increasingly isolated and low. She was looking for any way out. “*I cried every day*” (Amy). Recalling this in the interview, Amy was in tears. It was clear that suicide had been a strong possibility for her at one stage. “*I mean apart from...apart from leaving medical school I also think about harming myself sometimes... I just wanted to do something to make myself better... I mean I just wanted to maybe go to sleep forever*” (Amy). She had entered a state of complete hopelessness, which persisted despite her best efforts to move on. “*I just kept having this thought (self-harm and suicide) in my mind, quite often*” (Amy).

Throughout her first three years at medical school, Jess became increasingly low in mood. Her lack of a stable support network and her increasing isolation from her peers were feeding into her emotional pain – fuelling a dangerous, negative mindset.

I couldn't really look at anything without seeing it as a means to kill myself... I was having very intrusive thoughts about it that I couldn't control... So if I even just glanced at a balcony I would be like, "I could jump off that, that would probably work." Or just like a curtain rail and I would be like, "Oh I could probably just hang myself off that" (Jess).

During this difficult time, Jess contemplated suicide on a regular basis. *"it was definitely thoughts that I wasn't controlling... everything kind of suddenly had a very dark tint to it"* (Jess). Her mind was looking for any way out, against her conscious will. *"[I was] just kind of idolising death really"* (Jess).

Marking and Competition at Medical School

All three participants expressed concerns regarding medical school marking and the subsequent competition between students. This seemed to foster a non-supportive environment, where the struggles of one student might lead to the success of another due to competitive student ranking.

When she was feeling at her lowest, Jess felt unable to keep up with the academic demands of her second attempt at first year. Subsequently, she found herself resubmitting assignments from the previous year. *"I did the minimum amount of work. I resubmitted the exact same essays again... they didn't notice... Some of them went two grades up and some of them went two grades down"* (Jess). This contributed to feelings of helplessness. Jess's grades, and subsequently her whole career seemed to be based on such uncontrollable, subjective marking. This further fostered a sense of detachment and apathy in her view of medical education as a culture.

To me that just proved that all these essays are completely marker dependent. And it just even more showed just what a farce medical school is and how it defines where you are placed for the rest of your life. It defines what job you are going to get and how good your CV is and how many points you get in your application (for your first job as a doctor). It is all just rubbish really... And I guess no one else is going to have their eyes open to it – just how rubbish it all is (Jess).

Ryan discussed similar issues. He felt that the competitive environment of medical school was a negative one. He felt that this paved the way to a hostile student body. He attributed this to the UK medical education system of ranking students against one another in graduating deciles/percentiles instead of using a system based on grades.

I think one of the intrinsic problems of medical school is the fact that we are graded against each other across the five years... So, students who take that the wrong way can be quite damaging in terms of their sense of relationships to others (Ryan).

This may have contributed to a sense of vulnerability and hindered the construction of trusting relationships with his peers.

Amy also recalled difficulties with the competitive nature of medical school. She found that some of her peers would withhold knowledge, and refuse to help her, in order to get ahead themselves. “*But then some of them aren’t that supportive. So, they will keep it to themselves*” (Amy). This further exposed a potential hostility fostered through the competitive nature of undergraduate medical education in the UK.

Discussion

These cases exemplify three different sets of experiences, which highlight how medical students may develop HH. All three participants experienced helplessness – they were in inescapable, stressful situations. Amy and Jess also experienced hopelessness. Their attributions were *global, stable* and *internal* – the classic pre-requisites of hopeless depression (Hahner, 1989). Ryan did not experience hopelessness. His attributions were *specific, stable* and *external*. He was able to attribute his situation to a time-limited period of medical education. That prevented him from lapsing into hopelessness. The key difference in his attribution pattern was his specific attribution – Amy and Jess attributed globally. According to the hopelessness model of depression, the combination of global and stable attributions may be the key factor in developing depression (Metalsky et al., 1995).

Table 1

Participants’ Experiences of Helplessness, Hopelessness, and Suicidal Thoughts

ID N°	Gender	Pseudonym	Attributions	Feeling of Helplessness	Feeling of Hopelessness	Depression / Suicidal thoughts
1	F	“Amy”	Global, Stable, Internal	Yes	Yes	Yes – did not seek help
2	F	“Jess”	Global, Stable, Internal	Yes	Yes	Yes – diagnosed with depression
3	M	“Ryan”	Specific, Stable, External	Yes	No	No

Amy and Jess both experienced suicidality – a phenomena not shared with Ryan. Tan et al., found that hopelessness was indeed a predictor for suicidality in medical students (Tan et al., 2015). For Amy and Jess, the situation was dangerous. Their attributions did not include the possibility of change. However, increased supports helped Jess see an end to her problems. Whilst this was not achieved until several years later, it highlights the positive impact that supports can achieve.

Amy’s case highlights the terrible consequences of a passing comment made by a harsh tutor. Wider research has shown that, in children, teachers can play a pivotal role in their development of learned helplessness (Canino, 1981). One example of this is through the giving of feedback. Dweck et al. found significant gender differences within the feedback teachers were giving (Dweck et al., 1978). These teachers had a tendency to attribute a lack of effort to the failure of male students, but not to do so for females (Dweck et al., 1978). Whilst their research was specific to secondary school teachers, the parallel is obvious. From Amy’s recollection, it appears that her tutor may have attributed her quietness to a lack of knowledge

and, subsequently, implied laziness or ineptitude. This bears resemblance to the work of Dweck et al. and is an area requiring further study. Perhaps tutors should be taught to be aware of the impact that seemingly “throw away” comments might have on vulnerable students.

Jess’s experiences flag important questions. Might it be important to house medical students together during their first year of study? Buddying schemes might also ensure that students do not feel so isolated. Such schemes have been shown to be effective at the secondary education level for new students (Ferrante, 2012). Furthermore, one UK university is already offering just such a scheme to all students entering higher education there (Keele University, n.d.). Within this scheme, they make a conscious effort to try to pair students with a buddy from a similar background (Keele University, n.d.). Such schemes may well help to minimise the shock of coming to medical school. There is now a need for further research in this area. There is also a need to consider how we might better identify and support those who suffer as a result of the prevailing culture within medical schools. This goal is supported by the UK Royal College of Psychiatrists (2011), who have stated that “it is strongly recommended that all higher education institutions ensure that training in the recognition of mental disorder and suicide risk is offered to academic and other institutional staff who work with students.”

Ryan’s experience of a deep-seated sense of “if we do not talk about it, we do not need to acknowledge or feel bad about it” from others is interesting. Could this be the “culture” that students are indoctrinated into at medical school? Or could this, perhaps, be projected downwards from staff? This is an area requiring further research. Ryan also calls the ranking systems within medicine into question. Are we fostering a healthy competition between students? Or might we be fostering a ruthless competitiveness? Jacobs (2017) describes how medical students’ “workload is often made more burdensome by a cut-throat, ‘learn-or-go-home’ culture.” He goes on to highlight that “a medical school culture characterised by intimidation, fear and competitiveness can also lead to callous, uncompassionate behaviour towards patients” (Jacobs, 2017). This raises important issues with regards to what we are trying to achieve with our use of competitive ranking systems instead of grades. Whilst they may make job allocations simpler at a national level, could we be negatively impacting upon patient care as well as our students’ wellbeing? Further research into this is also needed.

The “culture” of medical schools is repeatedly mentioned above. As Heiman et al. (2019) ask, “is it the medical school culture that creates such high rates of depression?” Do we need to take a closer look at what we, in medical schools, are doing to our students? Why are the experiences of medical training (at medical school and as junior doctors) so brutalising that many junior doctors either consider quitting the profession or actually do quit the profession?

This study also highlights the importance of advertising supports to students. Whilst the ownership to take up such supports may rest with students; we can aim to maximise their knowledge of them. Heiman et al. (2019) also highlight that,

prior to seeking therapy, students will first reach out to a tutor, faculty member, or a friend... It is therefore important to identify when a medical student may be on the more introjective/depressive spectrum, and to appropriately refer them to therapy.

It may therefore be prudent to ensure that all teaching staff receive some form of training in this and are aware of potential supports/are able to signpost students to appropriate individuals/services.

This study reports the experiences of only three students. This is both a strength and a limitation. Small groups are ideally suited to phenomenological research, given the need to explore a similar experience in depth. Although this is not generalisable, it does allow for a greater depth of analysis and understanding. We report real stories. We can learn from their

experiences and try to develop strategies to support students who find themselves in such circumstances. From these three accounts, we have learnt about some situations that medical students can find themselves in. These can be devastating for the students concerned. For example, both Amy and Jess contemplated suicide. Ryan never considered taking his own life, but for him, the financial burdens meant that he was not able to engage in the student culture and become an integrated member of his cohort. We may need to consider how much of a barrier that may be to others who want to become doctors. Suffering in silence is something that was common to all three. In this day and age, can we really excuse cultures which promote this? How can we promote more caring, supportive educational environments? There will be many more examples of medical students who have lapsed into HH whose stories we do not hear. Some may have committed suicide. There are also likely to be many more ways in which HH are induced in them. Further research is needed in this field.

“I simply offer that we acknowledge the issue, name it, and address it where appropriate as part of our wider citizenship roles and duty of care to our future doctors.” (Gishen, 2019)

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