
Professional identity formation at medical school: a qualitative study to explore the effect of cultural factors on professional identity formation of medical undergraduates.

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Submitted in part fulfilment of the requirements of the degree of
Doctorate in Education (EdD)

December 2022

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Declaration

I, Joanne Harris, declare that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm this has been indicated in the thesis.

Joanne Harris, December 2022

Word count (exclusive of abstract, titles, appendices, references, reflective statement and impact statement and prior to amendments) **44,962 words.**

Abstract

Medical education is subject to competing discourses; the discourse of standardisation which promotes competencies and the discourse of diversity which celebrates inclusivity and difference. Recently the diversity discourse has encouraged widening participation to ensure the gender, social class and ethnicity of medical students reflects the composition of the population. However, this initiative is subject to the standardisation discourse often delivered by the hidden curriculum. Culturally diverse students experience dissonance from negative experiences and are expected to conform in ways that challenge their underlying identity. This study sought to explore the culture-related experiences of medical students and how they negotiated the discourses as they developed a professional identity.

Student data was collected at two contrasting medical schools in the UK via an online survey (n=79) and semi-structured interviews (n=12). Students described how cultural factors affected their experience at medical school and development of professionalism. Responses were analysed using Bourdieusian concepts of habitus, capital and field. The students' use of social constructivism to manage professionalism was explored through the lens of Goffman's performance theories.

Using Bourdieu's theory, medical school was considered as subfields of education and care giving. Students reported incidences of classism, sexism and racism particularly in the field of care giving and this challenged their habitus. The students demonstrated options including (i) maintaining their original habitus (ii) changing their habitus to match that expected by the discourse of standardisation or (iii) using social constructivism to manage their responses through impression management.

I observed some students acknowledging the competing discourses and using social constructivism to form emerging professional identities. As educators we can enable students to maintain this critical reflexivity and develop confidence to recognise the gaps in the system and adapt in appropriate ways. Students will therefore gain from being active participants in the system and can effect change.

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Impact statement

It is not easy to assess the impact of one's work whilst being fully immersed in it. Yet consideration of the impact of any research must consider what has gone before and what this body of work adds to the debate. With my social constructionist lens, I also need to consider the social and political contexts of this topic. This study examined the cultural aspects of professional identity formation of medical students. Medical professionalism is a well-researched field and initially I was encouraged to use the problem/gap/hook heuristic. (Lingard, 2015). This assumes that research dissemination is an ongoing dynamic social construct, with the researcher choosing an appropriate point to enter the conversation.

The discourse on medical professionalism has reached an interesting divergence between the doing or acting as a professional, often through the accumulation of competencies and the becoming a professional, or development of a professional identity. At the same time, an agenda to increase diversity in the medical profession through a scheme known as widening participation has led to a discourse of inclusivity and championing difference (Frost & Regehr, 2013). There is a tension between the positivist, competency based discourse and the more interpretivist, diversity discourse. This has led to uncertainty about what professionalism entails, with students experiencing the tension between the discourses, often delivered by the hidden curriculum. Culturally diverse students may have particular difficulties, with negative experiences causing emotional dissonance.

When looking at the social and political milieu in which this work is sited, there has been a change of discourse during the course of this EdD with an increased intolerance of discrimination and an effort to empower people to speak out about perceived injustices. However, it is apparent from the literature on gender and racial discrimination and recent publication of the Sewell report into racial disparities (Commission on Race and Ethnic Disparities, 2021), that discrimination is still prevalent in medicine. The barriers to citing injustices remain, especially in the

hierarchical medical profession with 'whistleblowers' themselves claiming discrimination.

Cultural awareness is becoming increasingly topical and my interest in this field has already been recognised more widely. I was invited to participate in a workshop on differential attainment in medical education attended by a member of the Sewell commission, and also take part in a debate on identity and transitions at the Association for Study of Medical Education (ASME) 2021 conference.

The cultural aspects of medical professionalism are rarely mentioned in empirical research and although students have given evidence of their (largely negative) cultural experiences at medical school and the dissonance they feel, this has not been linked to their developing professional identity. By using a social constructionist framework and the theory derived from the work of Bourdieu and Goffman, I have attempted to show how the students themselves navigate the competing discourses and manage this situation in an effort to forge their professional identities. I hope the prevailing interest in this topic will help to disseminate this research and inform future development in the field of medical education.

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Acknowledgements

There are many people who have enabled me to complete this doctoral study and who I wish to thank.

Sandra Leaton Gray, my supervisor since the early stages of this EdD who inspired me to take my first steps inside the world of social theory and particularly the work of Bourdieu.

Sophie Park, who as a supervisor in my field has constantly challenged my assumptions and introduced me to new ways of thinking. Both supervisors have understood my time pressures and known when to encourage or push to allow me to reach this stage.

Bryan Cunningham, who supervised the early stages of the EdD and then later thesis workshops and provided a calm and wise presence.

The very talented Faye Gishen, who started after me but very quickly overtook me in the EdD and has been my sounding board, as well as providing useful advice at every stage.

My wonderful colleagues at the University of Buckingham, who have allowed me to talk (in detail) about my EdD research and somehow always seem to look interested. Particularly to Joanne Selway and Jacqueline O'Dowd who achieved their own doctorates long ago and yet have been so encouraging.

Jamie Fox, whose wonderful computer skills helped me to format my diagrams and tables. Thank you for being so patient with your ageing mother.

I could not have gone on this journey without the space provided by my lovely husband and three children. My husband has just started his own doctorate and two of my children are pursuing postgraduate studies. I find myself providing support and advice to others and so completing the circle.

Reflective statement

In this section, I reflect on the components of the Doctorate in Education (EdD) and the impact on my practice as an educator and clinician. I look back on my previous reflective statements written earlier in this doctorate, doing a sense check on the current relevance of my self-analysis. I draw on Bryan Cunningham's views on the transformative aspects of required reflection and hope this demonstrates evidence of my development as a 'pensive' practitioner (Cunningham, 2018).

I commenced this doctorate in October 2014 shortly after completing my Master's in medical education. My reasons for continuing to study were complex. I missed the rigour of academia but also wanted to prove myself to colleagues. I had recently been appointed to Faculty and thought a doctorate would enhance my career prospects. However, I also hoped academic study would provide an evidence-base for my nascent educational thinking. I approached the course with some trepidation wondering how this would fit with my busy life as a general practitioner and Director of Curriculum at a London medical school. As I wrote in 2015,

I had many initial concerns. Could I write at Doctoral level? Would my topics both fulfil the criteria of the assignments and also be relevant to the workplace? (Harris, 2015 p.1)

As a medical professional trained in a positivist scientific method would I be able to make the necessary switch to the social science world of education research?

One colleague had left the programme early, and other discussions made me realise this could be a 'bumpy ride' with 'many a slip twixt cup and lip' (Gill *et al.*, 2009

p.604). The role of a medical education leader has been described as a meta-medical educator with the challenges of negotiating the often-competing discourses of clinical work, scholarship and research (Park *et al.*, 2014). However, I remembered from my Masters', that research related to current practice enhanced my self-efficacy in the role and decided this was the course for me.

Early days

Looking back to the first module on **Foundations of Professionalism (FOP)**, I was fortunate to have Bryan Cunningham as my supervisor as his considered wisdom and astute thinking provided an optimal start to Doctoral level studies.

Professionalism seemed an appropriate initial topic as my original doctoral research proposal was to design and evaluate a tool to assess professionalism; something that like many initial research proposals was much too broad. Contact days at IOE and group work with my colleagues helped to clarify my thoughts. I was struck from our discussions and the recommended readings in *Exploring Professionalism* that similar changing discourses occur across all professions; those of performativity, increasing regulation and a reduction in autonomy (Cunningham, 2008).

I was the only doctor in my group and had to fight the general assumption that the medical profession had already succeeded in defining and codifying professional standards. In an effort to counter the idealism of my fellow students, I selected a potentially controversial topic for the FOP assessment. I chose to discuss altruism and why in the light of the recent medical malpractice scandals and societal changes I felt it should no longer be included in the definition of medical professionalism. In my view, subscribing to altruism puts doctors on a pedestal and assumes values that are not possible to uphold in the 24/7 modern world of medical care. I enjoyed formulating these arguments and this essay was later published in *Health Professions Education* (Harris, 2018).

Learning a new language

Commencing **Methods of Enquiry 1 (MOE1)** and **Methods of Enquiry 2 (MOE2)** the following year left me on shakier ground. I mentioned in my 2015 reflection that methodology was not my strong point and that I remained 'significantly confused about the 'ologies' (Harris, 2015). After nearly 30 years as a medical professional using standard medical jargon, I now needed to learn a new language, that of social science research.

Language is important as a means of communicating one's thoughts but also of defining your identity within a particular group. As I read more about structuralism, power and embodied identities, I became aware how language is used to become part of a discourse (Tajfel, 1974). I was already using the medical language and practices described by Foucault (1973) in *The Birth of the Clinic* as the medical gaze. According to Bourdieu (1977), this forms part of my cultural capital allowing me to maintain my habitus as a medical professional in the field of medicine. Now I was back at the beginning, needing to learn a social science language and follow a new set of rules. Cunningham (2018) discusses how acquiring language skills through a course of doctoral study can empower individuals to access academia and this was also my experience. However, reading also made me aware of the power residing in a dominant discourse and how use of language allows us to take certain practices for granted. I now better understand the need for reflexivity and to 'make strange' what may be considered accepted wisdom (Kuper *et al.*, 2010).

In the taught courses, I continued to pursue the topics of medical professionalism and assessment, and this helped to cement my world view into an interpretivist epistemology and particularly a constructionist approach. Constructionism is based on the premise that what we know about the world is created through social interaction (Burr, 2015). As I read more widely, I saw that professionalism could not be only assessed by amassing a series of competencies but considered in the context of interactions between individuals and the wider social world.

In MOE2, I interviewed clinicians to discover what they were drawing on when assessing students for professionalism and chose to analyse the data using grounded theory (Glaser & Strauss, 1999). I selected this tool somewhat blindly without realising the complexity of this method or the time required and learned from this a need to be pragmatic in my doctoral research.

Beginning to let go

The end of MOE2 heralded the beginning of the year-long Institution Focused Study (IFS) and the start of working independently with supervision. Although there were some contact days, there was an expectation for mainly self-directed learning. I had realised during the taught courses that I am a social learner and almost value the coffee-queue conversations more than the presentations when attending academic conferences. I missed sharing the frustrations and difficulties of pursuing a doctorate with my fellow students. I had also never worked with a supervisor before and had to adjust to this new educational relationship. I recognised I was a challenging student, often prioritising my job over my studies.

In the IFS, I continued the theme of looking at assessment of professionalism from the point of view of the assessors, focusing on the well-known theme of failing to fail (Dudek *et al.*, 2005). My supervisor encouraged broader thinking, reading more widely around the topics of professionalism and the underlying societal changes in the medical profession. I read about Bourdieu's theory of habitus, capital and field and found this resonated with my views on how medical students developed their professional persona. My initial readings on performativity and managerialism in professionalism in FoP became focussed on the writings of Foucault and his view of capillary power shifts. This became a useful lens to explore reasons for clinicians not highlighting underperforming students and I decided to analyse my participant data using a Foucauldian discourse analysis (Arribas-Ayllon & Walkerdine, 2009).

Failing to fail was a topical subject with the increase in workplace-based assessment in the medical education field. Although much was written about this, I had empirical

data from educators which was more unusual, and I was invited to present at several education conferences and a GMC workshop.

Thrown off course

I completed the IFS in 2017 on somewhat of a high, feeling ready to embark on my thesis but unfortunately this sensation soon began to unravel. I was unsure where I wanted to go with the topic of professionalism with the clinician interviews having run their course. I recognised that I probably needed to switch my focus to medical students' views of professionalism, but I was nervous of the difficulties in recruiting students either at my own institution (insider bias) or at another institution (gatekeeper effects). I now had two supervisors, but initial supervisions left me feeling inadequate and unsure how I could bridge the gap to reach an appropriate academic level. My education role was not going well since as a general practitioner I was not receiving full recognition as a medical education leader in my science focussed institution, something I expanded on in my position statement for the IFS (Harris, 2017).

Then in December 2018, I was admitted to hospital with a stroke, perhaps a message that I was trying to take on too much? Fortunately, I made a full recovery, however like many life events this provided the necessary impetus to get back on track. In 2019, I moved medical schools to become the Dean of a small independent medical school without government funding. Alongside this new role, I continued exploring the nature and competing discourses of professionalism and whether professionalism was predominantly considered another competency to be achieved or was more associated with a change in professional identity. I was also aware of growing widening participation (WP) discourse with links to diversity in medicine and started to consider how this interacted with a discourse of competency and theories of professional identity formation.

I decided this would be the focus of my thesis and entered the upgrade process. Initially, I was only considering WP in terms of socio-economic factors. Changing my

terminology to the word culture has extended the scope of this thesis to include the issues of gender and race and ethnicity, with the Black Lives Matter movement making the latter increasingly topical during the course of my study.

I had commenced interviewing participants when the COVID-19 pandemic started and data collection for doctorates ceased. I did very little academic work in 2020 but again a crisis provided extra impetus, as home working in the lockdown spurred me onto arranging telephone interviews and start writing. I submitted a few draft chapters and was inspired by the realisation that I might actually complete this doctorate.

Writing in itself has been harder than expected with requirements to follow a certain approved style (Billig, 2013). I am also sympathetic to Kamler and Thomson's view (2014, p.2) that we should not call the writing of the dissertation the 'write up', as this reductionist term implies a simple task added at the end. My experience of writing this thesis has been extremely demanding but helped to clarify and develop my analysis. A recent conference introduced me to the idea of 'writing as an epistemological tool' (Chen, 2019), and I agree that the process of writing has been fundamental in developing my understanding about this topic.

Final thoughts

The EdD has been a long process with many stops and starts along the way. However, I have grown not only as an academic but also as an educator and clinician. Although my clinical practice expects me to reflect, the requirement in the EdD to articulate reflections in writing has helped to turn me into a pensive professional (Cunningham, 2018).

Working in the paradigm of social constructionism has heightened my awareness that the accepted practices in medicine and education are a product of our social world. Previously a positivist working within clear-cut boundaries, I am able to see the nuances of an interpretivist world-view. Setting this body of work within my own

professional field has required me to reconsider every aspect of my working life. Current practices are not set in stone but are a product of the discourse and the prevailing power dynamics. This has enhanced my practice both as a leader in education and general practitioner. Cunningham (2018) describes research, writing and reflection as disruptive processes, and educational research has certainly impacted my life, confirming me in a career path I had never considered on graduating as a doctor. And what next? As a committed lifelong learner, I look forward to new development opportunities.

Words 1999

Chapter 1 – Introduction

‘Medical education seems to be in a perpetual state of unrest... How did this situation arise, and what can be done about it?’ (Cooke et al., 2006 p.1339)

Background

This thesis is part of a professional doctorate arising from observations in my professional career and examines the varied cultural experiences of undergraduate medical students as they develop a professional identity to become doctors. As a social constructionist study, it considers the changing perception of the role of doctors in society, which mirrors the societal changes evolving over the past 70 years and discusses how these have driven the introduction of a new professionalism framework. It explores how the early identity of the students, their individual and group interactions, together with the institutional effects of the medical world, all combine to influence their emerging professional identity as doctors. Through a questionnaire and interviews, it further examines the dissonance that culturally diverse students at two contrasting medical schools may face when their experiences are in conflict with their developing professional identity. It then goes on to suggest a social constructivist model that explains how medical students manage this dissonance and incorporate these experiences into their emerging professional identities.

The study is based in a sociology framework and considers that knowledge is created through the interpretivist lens of interactions in the social world. It explores two competing theoretical paradigms, or ways of understanding the world, and shows how the division between these paradigms has contributed to the confusion around the teaching of medical professionalism. These paradigms are represented by the *positivist* and *interpretivist* discourses (Pring, 2015). Throughout this study, I am using the term discourse to refer not only to what is said or written but to the

everyday practices, themes and shared ideas adopted, either consciously or unconsciously, that define the way an individual sees the world (Fox, 1993).

The positivist discourse considers that knowledge is reliably reproduced through the underlying *structure* of institutions whereas the interpretivist discourse regards knowledge as being constructed by individuals and their social interactions (Cohen, *et al.*, 2017; Pring, 2015). Social constructionism is a type of interpretivism, which suggests that knowledge is constructed through interactions in a social world, and that different constructions of the world may elicit different behaviours (Rees *et al.*, 2020). This study is carried out in a social *constructionist* framework. However, when considering how the medical students are managing their emerging professional identities, I call on a social *constructivist* theme. The terms constructionism and constructivism are often used interchangeably and yet have important differences with constructivism focussing more on the individual controlling the construction process (Burr, 2015). Maintaining the sociology focus, this thesis uses the theories of Pierre Bourdieu (1930-2002) and Erving Goffman (1922-1982) to analyse the data, together with a consideration of the hidden curriculum explored by Frederick Hafferty, and other social medical education research developed in the 20th century. A table presenting the paradigmatic divide in terms of understanding and creation of knowledge how the theories of Bourdieu, Goffman and Hafferty fit into this framework, is seen below (Table 1).

Table 1: Comparison of understanding of knowledge in the competing paradigms and consideration of the theories of Bourdieu, Goffman and Hafferty in this framework.

	Discourse of standardisation	Discourse of diversity
<i>Linked research paradigm</i>	Postivism	Interpretivism
<i>Nature of knowledge</i>	Hypotheses to be verified and established as fact	Individual reconstructions coalescing around consensus
<i>Knowledge accumulation</i>	Building blocks adding to a body of knowledge to allow for future generalization	Lived experience adding to more informed and sophisticated reconstructions
<i>Sociological paradigms</i>	Based on <i>Structural functionalism</i> . Social institutions contribute to social stability, which is necessary for a healthy and strong society. There is a focus on <i>structure</i> with stable roles that are transmitted mostly unchanged to future generations.	Based on <i>Symbolic interactionism</i> . Society is constructed by individuals through a range of symbols (words and gestures) and interactions. Roles are developed through social interactions with a focus on individual <i>agency</i> .
Social theories of Bourdieu	←	→
<i>Habitus, capital and field</i> (Bourdieu, 1977)	e.g., describes the <i>doxa</i> in the field as the accepted wisdom and states that habitus is (relatively) durable. Early research denies agency as he believes changes to habitus are unconscious.	Shows evidence of changes in habitus and society caused by the impact of capital on an individual within a field i.e., individual social interactions. In later research agreed that individuals were utilising capital in a conscious way to change their habitus, so allowing for agency.
<i>Doxa, symbolic violence</i> (Bourdieu & Wacquant, 1992)	A sociologist in France in the 1970s where the dominant social paradigm involved structure. However, he changed throughout his life and is described as a post-structuralist since his theories bridge the paradigms.	Was thought to be influenced by Goffman's writing which he saw as a counterpoint to the predominantly structural views in France the time.
Social theories of Goffman	←	→
<i>Dramaturgy, impression management</i> (Goffman, 1959, 1961)	Recognised the place of stable structure in society by describing asylums as <i>total institutions</i> or closed spaces where social interactions can occur.	Often described as symbolic interactionist or social anthropologist. Described social theories involving individual agency. Change is effected through the interactions that occur on the frontstage and backstage as individuals seek to manage how they are perceived by others (impression management).

<p>Social theories of Hafferty</p> <p><i>The Hidden Curriculum</i></p> <p>'A set of unstated tacit rules that occur at all levels of society'</p>	<p style="text-align: center;">←—————→</p> <p>Underlying and implicit messages that signifies the culture and practices of an institution. At institutional level relatively durable and resistant to change</p> <p>Also used the concept of <i>total institutions</i> to describe closed space of a medical school.</p>	<p>Individual social interactions e.g., through role models are a way for hidden curriculum messages to be transmitted and social change to be enacted.</p> <p>(based on Guba & Lincoln, 2005)</p>
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Empirical framework

This thesis is situated within medical education; part of the medical world and itself part of a wider social context. It considers the various societal and political shifts in the 20th century which have affected the medical environment and changed how the medical profession is viewed in society (Berwick, 2009; Goddard & Patel, 2021). Until the mid-twentieth century, doctors were treated with a degree of respect and granted autonomy in return for educating themselves in a body of knowledge and placing patients' interests above their own (Collier, 2012; Stephenson *et al.*, 2001). However, societal changes occurring from the 1950s onwards, with an increasingly educated population, meant that doctors no longer had exclusive access to this body of knowledge (Freidson, 1970; Johnson, 1972). This loss of 'epistemological authority' on behalf of the medical profession has contributed to the reduction in their autonomy (Barnett, 2008 p.191).

Other societal changes in the late 20th century led to a shift in the way all professions were viewed (Ball, 2008). The democratisation of society provided a route to a rise in the free market economy, with the governance of many institutions moving from the public to the private sector (Canter, 2016). This move of economic liberalization with free trade, deregulation and a reduction in central government control is known as *neoliberalism* but conversely has led to professionals feeling more controlled (Gray *et al.*, 2015; Leaton Gray, 2013). Subsequent managerialism led to the introduction of managers from outside the professions with the intention of improving

performance (Gray *et al.*, 2015). The resultant drive to monitor costs and resources meant that many professions were subject to performativity and accountability measures, with previous autonomous experts now expected to act as regulated professionals (Ball, 2003; Barnett, 2008). This rise in managerialism has led to a confusion amongst professionals who feel their status has been reduced to that of employee or technician and their identity as a professional is being questioned (Barnett, 2008; Canter 2016; Hendrikx, 2020).

In medicine, the managerialism initiatives to control costs in the NHS, have given rise to policies such as the quality and outcomes framework (QOF) in general practice and the NHS managers controlling hospital budgets and waiting lists in hospital medicine. The competency/performance model in medicine has arisen from the positivist discourse as a consequence of the increased monitoring of an individual's actions and caused many doctors to feel that their professional autonomy has been eroded (Berwick, 2009; Speed & Gabe, 2013). Many educators from the opposing discourse of diversity, feel that competencies are a proxy marker for acquisition of knowledge and need to be used with caution (Hodges, 2006; Jarvis Selinger *et al.*, 2012; Park, 2012).

In addition to these societal changes, the profession was affected by several medical malpractice scandals of the late 20th century. These included Harold Shipman, a GP who was found to have murdered more than two hundred patients (Smith, 2004), the Bristol children heart surgery scandal (Kennedy, 2001), and the Alder Hey organ harvesting scandal (Redfern, 2001). Together malpractice scandals have collectively reduced the level of trust in the medical profession (Field & Scotland, 2004). Medical professionals are no longer seen as knowledgeable, omnipotent, and acting only in the interests of their patients (Rosen & Dewar, 2004). Following the Shipman enquiry (2004), the public called for the profession to lose its ability to self-regulate, with measures suggested to increase public involvement and empowerment (Field & Scotland, 2004). The GMC and senior medical leaders were therefore pressurised to increase regulation, reduce medical autonomy and to reframe professionalism teaching in medicine (GMC, 2009; RCP, 2005).

The societal changes and malpractice scandals have led to what many are calling the rise of the *new professionalism* in medicine (Canter, 2016; Light, 2010; Speed & Gabe, 2013). This new professionalism is based on three main areas all acting to reduce professional dominance in medicine and emanating from the positivist discourse, (i) accountability to a competency/ performance model (ii) a shift from inherent trust to enforceable or informed trust (iii) an ability for non-physicians such as physician associates to undertake clinical work (Speed & Gabe, 2013).

The rise of competing discourses

However, discursive confusion has arisen from within the profession, as despite the competencies mentioned above, the post Shipman definitions of professionalism have stressed altruism and a return to a virtue-based professionalism (Coulehan, 2005; Field & Scotland, 2005; RCP, 2005, Rosen & Dewar, 2004). These ideas from the interpretivist discourse are at odds with competency-based professionalism, and matters are further confused by the presence of hierarchies in medicine. Throughout these societal changes, the medical profession has been keen to maintain its original hierarchies, in an effort to resist managerial control (Bleakley *et al.*, 2011). This includes the dominance of consultants over other clinicians with labelling all training doctors as junior until they become consultants (Ratcliffe, 2012). This is significant for this study as a hierarchical profession may be less open to diversity and a changing composition of the workforce. This is an example of conflict between competing paradigms of positivism or *standardisation* and interpretivism or *diversity*.

In medicine, the positivist discourse of standardisation promotes the view that there is one preferred way to be a successful doctor to provide optimum patient care and the trainee doctor needs to meet these through a series of competencies (Frank *et al.*, 2010). In contrast, the interpretivist discourse of diversity celebrates individuality and difference, suggesting that a heterogeneity of approaches will be beneficial to the medical profession and patient care (Frost & Regehr, 2013). Both discourses clearly confer important benefits on the medical profession and could usefully be

considered together, for example in the use of standards such as contextual admissions to help implement a widening participation (WP) agenda (Razak *et al.*, 2015).

However, unfortunately this rarely happens, and the rhetoric and practices have firmly divided supporters into separate fields with little shared understanding and a resultant tension (Frost & Regehr, 2013; Hodges, 2020). This discursive confusion is further discussed when considering the sociology of medical education in Chapter 2 (p.31).

The situation is complex with initiatives stemming from one discourse often subject to policy decisions from the other discourse. For example, it is the diversity discourse that has driven the widening participation agenda to increase the gender, ethnic and socio-economic mix of students at medical school with consequent shifts in the composition of the medical student population (Garlick & Brown, 2008; MSC, 2014). However, this agenda is also impacted by the standardisation discourse with a reluctance to introduce contextual admissions or lower entry standards for those who have perhaps not experienced the same educational opportunities (Apampa *et al.*, 2019). Once these diverse students arrive at medical school, they are also exposed to the positivist paradigm of competency with an expectation to conform. Therefore, despite the WP agenda professing a desire to make changes, the observations in the field are of mixed messages which are causing inaction (*ibid.*).

Therefore, there is an increasingly diverse medical student body generated to fulfil the needs of the diversity discourse, who experience dissonance in their emerging professional formation, often due to the conflict with the discourse of standardisation. Psychologists have researched this dissonance and termed this *moral injury* or the psychological sequelae from experiencing events that transgress deeply held beliefs (Dean *et al.*, 2019). This moral injury phenomenon has also been noted in medical students whose negative experiences of pre-hospital care affected their sense of self and what they felt was right (Murray *et al.*, 2018).

In education, these areas of conflict may be presented through the *hidden curriculum*, defined as 'a set of influences that function at the level of the organisational structure and culture' (Hafferty, 1998) These are tacit rules that exist alongside the more formal curriculum and are present in every institution (Hafferty & O'Donnell, 2014). The hidden curriculum signals to the student 'this is the way we do things around here' (Hafferty, 1998 p.404) and is thought to deliver much of the professionalism teaching at medical school (Brosnan, 2009). The hidden curriculum is considered in more detail in Chapter 3 (p.78). In this study, I explore how many of the negative experiences related by the students may be delivered by the hidden curriculum.

Medical professionalism

This study discusses how the competing discourses have led to a divergence of understanding in the medical education literature which has impeded the development of an overarching theory of medical education (Brosnan, 2009). These discourses are in conflict and may also have contributed to the confusion surrounding professionalism (Hodges, 2010; 2021; Frost & Regehr, 2013).

It is uncertain whether professionalism is considered in the positivist tradition, a set of specific actions to be followed (Cruess & Cruess, 1997) the so-called 'doing of professionalism', or whether it involves an interpretivist sociologically constructed change in persona, or professional identity formation, the so-called 'being of professionalism' (Cruess *et al.*, 2016; Monrouxe, 2010). There are contested views about whether we should be considering professional behaviours (Frank *et al.*, 2010), professional identity formation (Hafferty, 2016) or even professional virtues (Daaleman, 2011, Irby & Hamstra, 2016). It is likely that this reactive and fragmentary approach has led to the confusion around the nature of professionalism.

There is no broad agreement about the definition of medical professionalism with many definitions in use (for example Cruess *et al.*, 2004; Kirk, 2007; RCP, 2005; Rosen & Dewar, 2004; Swick, 2000). Most doctors would agree with the 2005, Royal College of Physicians (RCP) definition as a 'set of values, behaviours and

relationships that underpin the trust the public has in doctors' (RCP, 2005 p.14). However, the inclusion of altruism and mastery as concepts in this definition was disputed at the time (Wass, 2006). The RCP has clarified aspects of this definition in *Advancing Medical Professionalism* in line with the changes that have occurred in society and healthcare (Tweedie *et al.*, 2018). The report retains the importance of trust in the profession, and rather than writing a new definition 'seeks to explain, expand and interpret this definition for healthcare in 2018 (*ibid.* p.9). The report considers the professionalism of a doctor in seven aspects of their working life, for example, 'doctor as a healer' and 'doctor as a manager and leader' and it is this expanded definition that I am choosing to use when discussing medical professionalism in this study. Medical professionalism formation is discussed in more detail in Chapter 2 (p. 45).

Reflexivity

As this is a professional doctorate, I have considered my own positionality in this research field. My interest in medical education and professionalism has developed over the past twenty years as I focused on a leadership role in a large London medical school and more recently as Dean of a smaller independent medical school in the Home Counties. I have observed at first hand, students in difficulty demonstrating unprofessional behaviours deemed incompatible with becoming a doctor. Despite a recent focus on teaching professionalism at medical school, and widespread definitions mentioned above, the students find it hard to understand what is required of them to become a medical professional (Irby & Hamstra, 2016). They feel professional attributes at medical school are defined largely by what is unprofessional and the basis of professionalism is poorly taught (Riley & Kumar, 2012; Byszewski *et al.*, 2015). There is a lack of agreement about whether values, attitudes or behaviours characterise the essence of being a doctor with definitions of medical professionalism often including desirable conceptual attitudes such as altruism and integrity, and yet students being assessed on behaviours (Ginsburg *et al.*, 2000; Jha *et al.*, 2006). Medical students remain confused as evidenced by a

GMC survey into student attitudes showing mixed responses to questions about honesty and professional boundaries (Gillett, 2015).

My medical school has also joined the recent national drive to widen the participation of the student cohort to more greatly reflect the population they will be serving (MSC, 2014). Studies often concentrate on the academic progress of culturally diverse students through medical school rather than possible challenges in developing a professional identity (Garlick & Brown, 2008). Some studies have noted a higher attrition rate in students from lower socio-economic backgrounds and other marginalised groups but have not considered the link to their experiences at medical school (Brewer & Grbic, 2010; Nguyen *et al.*, 2022). Many of the students in difficulty I encounter through the course of my work come from these WP backgrounds. This study aims to explore the experiences of these diverse students and how this may affect their sense of developing professionalism as a doctor.

Examining my positionality and current role in medical education, I need to address my presentation as a white female, exploring aspects of culture. I also work at a medical school where the students pay high fees while researching elements of wanting to widen participation into lower socio-economic groups. However, this medical school admits more than 50% of students from overseas with a resultant high proportion of black and minority ethnic (BME) students. I have maintained constant reflexivity in this study considering my ideas and opinions to ensure they are not overly biasing the participant views. I consider my reflexivity in more detail in the methodology Chapter 4 (p. 88).

The terms BAME (Black, Asian and minority ethnic) and BME (Black and minority ethnic) are used by the Medical School Council and GMC as a shorthand for non-white students. These terms have been criticised because they emphasise certain ethnic minority groups (Asian and Black) whilst excluding others (Mixed, Other and White ethnic minority groups) (Race Disparity Unit, 2021). The recent Sewell report into Race and Ethnic Disparities has a section entitled 'Why BAME doesn't work' and says this should be dropped as an umbrella term as it often allows employers to

highlight successes of some BAME people in their organisation whilst ignoring the difficulties of others (Commission on Race and Ethnic Disparities, 2021). Whilst being aware of its limitations, I have chosen to use the term BME in this research since this is broadly understood by individuals and educational organisations (Advance HE, 2020; MSC, 2019a) but have highlighted the subcategories of this term where appropriate.

Although I have been involved in social science for some years, my early medical background was connected with positivist scientific research. Undertaking a Masters' and then a professional doctorate in education has involved a personal paradigm shift to an interpretivist methodology. One key part of interpretivist research is the involvement of the researcher in the actual research process where 'researchers are the instruments of the research' (Cohen *et al.*, 2017 p. 289). Rather than ensuring independence from the research field, interpretivist research acknowledges and even champions the researcher's involvement and uses this to generate increasingly rich data and further inform the social world (Burr, 2015). It is appropriate for a professional doctorate to embrace insider research of this nature, but it is important to maintain reflexivity and be aware of the power relationships that may be present and influence the data collection (Robson, 2011). For this reason, I chose to conduct this research at two contrasting medical schools where I do not have a professional role. As a constructionist study, I use a qualitative methodology of a questionnaire with free text comments and semi-structured interviews.

Analytical framework

As a study within a sociological framework, it was important for me to use social theory to analyse the data. In recent years medical education research, has often been accused of an absence of sociology theory (Hodges & Kuper, 2012; Vinson, 2021). The majority of education research although qualitative, has largely comprised of cognitive processes designed to improve the output of education, so called research *for* medical education and been less aligned to underlying social theory, or the research *of* medical education (Albert *et al.*, 2007; Hirshfield, 2021).

One of the causes for this issue has been the presence of the competing paradigms (Hafferty, 2020), and therefore this thesis attempts to merge these paradigms to obtain a complete picture of the functioning of the social world of medical education and of professional identity formation.

One way to bridge the gap between the paradigms is to use the conceptual lens drawn from Pierre Bourdieu's sociological framework. Bourdieu described the theory of *habitus*, *capital* and *field* to discuss social mobility in a variety of social settings (Swartz, 1997). He considered the background habitus or underlying norms of the individual and how this interacts with capital in different fields to introduce social change (Bourdieu, 1977). Bourdieu was keen to overcome the divide between the paradigms and encouraged us to think relationally by applying reflexivity at every stage of the research (Bourdieu & Wacquant, 1992). I have chosen to use this theory since it allows me to consider both the structural and agentic aspects of social change when analysing the participant data.

I move to a social constructivist framework when considering how the students deal with the impact of the negative experiences and adapt to change. I apply the dramaturgy theory of Erving Goffman who explained interactions in the social world through a frontstage and backstage divide (Goffman, 1959). Goffman is usually depicted as a symbolic interactionist or social anthropologist; interpretations often linked to an ethnographic methodology. However, Goffman has also been described as a 'hero-anthropologist' who operates on many different levels and can be interpreted in a variety of ways (Collins, 1980). Therefore, this study, although not an ethnography, is able to take note of Goffman's theory and consider its application to this constructionist study.

In the *Presentation of Self in Everyday Life*, Goffman described how the frontstage performances were more formal and considered, with individuals employing *impression management* to control the way they were seen by others (Goffman, 1959; Lewin & Reeves, 2011). The backstage performances were generally relaxed and informal but often used as a way to rehearse or plan the frontstage activities

(*ibid.*) This study demonstrates, in an echo of Goffman's description, how the students utilise impression management to project a persona of professionalism as they forge their developing professional identities. I discuss in more detail my reasons for choosing the theories of Bourdieu and Goffman to analyse the data in Chapter 2 (pp.48-62).

This topic is currently being keenly debated with the rise of Black Lives Matter (BLM) and the #MeToo movement and awareness around differential attainment for minorities in postgraduate medicine (Adebowale & Rao, 2020; Cobb & Horeck, 2018; Woolf, 2020). There is widespread concern over this issue, but it is not clear how the situation can be solved through institutional social change alone. Therefore, as with every social phenomenon, there is a place to look at the interactions and behaviour of the individuals who encompass this social world.

Students whose identity is challenged have choices about how to respond; they can conform to the expected identity, or they can retain their original identity (Costello, 2005). There is research to show that students whose identity is challenged and feel forced to conform are prone to cynicism and increased levels of stress, burnout and deteriorating mental health (Kachel *et al.*, 2020; Wear *et al.*, 2006). Alongside other Deans, I have noted the large increases in adverse mental health issues amongst medical students in my own institution in recent years. Similarly, diverse students who are keen to retain their own identity may have difficulty in progressing at medical school within the discourse of competency (Frost & Regehr, 2012). Again, I have experienced some students in my own medical school who have difficulties in conforming due to their cultural issues and are subject to disciplinary processes or even Fitness to Practise.

However, there is a third way, and some authors have noted that where students are aware of the competing discourses that they are not passive recipients but are using social constructivism to manage the tensions and negotiate their emerging professional identities (Costello, 2005; Frost & Regehr, 2013; Monrouxe, 2009). Monrouxe and Rees (2012) have noted students using bedside teaching as a discourse to actively construct and re-construct their developing professionalism. In

this way some students are active agents choosing to express or hide aspects of their identity at different stages of their medical training and use 'both discourses to construct a hybrid identity that is based on both standards and individuality' (Frost & Regehr, 2013 p.1574).

The gap in the literature

Whilst medical student identity has been linked to Bourdieu's theory of habitus, capital and field (Brosnan, 2009; 2010; Sinclair, 1997), there has not been discussion of the cultural diversity of students and how the frequent *microaggressions* or subtle insults experienced by minorities could be interpreted in the light of Bourdieusian theory. Luke used the concept of medical habitus to discuss the transition made from medical student to junior doctor in Australia but did not further discuss how the doctors were dealing with their negative experiences (Luke, 2003). There have been some reports of medical students and doctors presenting a professional identity persona through the lens of Goffman's performance theories (Monrouxe *et al.*, 2009; Lewin & Reeves, 2011; Patel *et al.*, 2018) but again this has not been linked to cultural diversity. The dissonance due to the hidden curriculum has been documented (Monrouxe & Rees, 2012; 2017) but with limited discussion about how students act in light of these experiences to preserve their developing identities (Costello, 2005). Although social constructionism / constructivism is discussed as a theoretical tool for professional identity formation (Frost & Regehr, 2013), I was not able to find other studies that had gathered data to explore diverse medical students employing constructivism to manage negative experiences and dissonance.

This thesis is therefore well placed to build on previous research and explore through a social constructionist lens the effects of cultural experience on medical students and how this affects their professional identity. An understanding of the realities of the medical profession and the difficulties of introducing social change mean that the student individual actions need to be considered. This study explores how the students use constructivism to manage their response to the negative experiences and forge their professional identity. This is important in the medical profession as

there are increasing numbers of diverse students who may be at risk of leaving the profession. Dissonance may lead to cynicism and adverse mental health outcomes, if students do not manage this process and develop a professional identity allowing them to practise successfully as doctors. Some insight into the methods students are choosing to negotiate this challenging path will give information to medical schools about how best to provide support to an increasingly diverse body of students.

Chapter 2: Sociological concepts of the paradigmatic divide

'The sociological study of medical education, like many other academic endeavours, is a dynamic, contentious and sometimes unruly beast. Ways of seeing and knowing are 'discovered', disappear and are resurrected across windless waves of understanding' (Hafferty, 2000 p. 238).

This is a study exploring the effects of cultural experiences on professional identity formation of medical students and how the competing paradigms in medical education have disrupted a full understanding of the issues, leading to what some are calling a professional identity crisis (Costello, 2005). Having explained the underlying premise for this research in the introductory chapter, I now explore the literature that underpins the rationale for this work. I have chosen to divide the literature review into two chapters. Chapter 2 looks at the emergence of the competing paradigms in sociology and how these paradigms have contributed to theories around identity and professional identity formation. I introduce the theories of Bourdieu and Goffman and discuss how these analytical frameworks may be used to combine the paradigms. Chapter 3 then explores the literature around the observed effect of competing paradigms on two main areas in medicine, and the tensions between the discourses.

The sociology of medical education

In retrospect it seems remarkable that so many of us spent 20 years debating whether medical students were "boys in white" or "student-physicians"...It is time to expand from this body of work, however insightful, to institutional and comparative analysis' (Light, 1988, pp. 312-3)

To understand how professional identity is conceived in the light of the competing paradigms, it is necessary to consider a brief history of medical sociology; how the paradigmatic debate arose in sociology and then contributed to inhibit further theory driven medical education research. I also explore two early seminal studies into medical student socialisation from around sixty years ago; Merton's 1957 study, *The student-physician* (Merton *et al.*, 1957) and Becker's better known description of

medical socialisation, '*Boys in White*' (Becker *et al.*, 1961). These studies are frequently referenced when discussing the professional identity formation of medical students.

Medical sociology came to be considered as a specialty separate to sociology in the middle of the last century (Kuper *et al.*, 2010). Prior to this, it had been mostly aligned to psychiatry and linked to research of medical problems, the so-called sociology *in* medicine (Straus, 1957). However, as medical sociology became recognised as a discipline in its own right with a growing output of medical education research, it was almost immediately subjected to the paradigmatic debate, about the way knowledge was created, between the positivist *structural functionalism* discourse and the interpretivist *symbolic interactionism* (Cockerham & Scambler, 2010).

Structural functionalism, which arose from the views of Parsons (1951), described social development occurring at the institutional level in a stepwise fashion with an emphasis on 'value consensus, social order, stability and functional processes' (Cockerham & Scambler, 2010 p. 6). This paradigm suggests professional formation occurs in a prescribed manner with individuals adopting the accepted norms and values to gain a professional role (Costello, 2005; Miller, 2010). Conversely, *symbolic interactionism*, a form of interpretivism, arose from the theories of Mead (1934) and Blumer (1969) and maintains that social reality is constructed by 'individuals interacting with one another on the basis of shared symbolic meanings' (Cockerham & Scambler, 2010 p. 7). In this paradigm, professional formation is driven by the motivation of individuals seeking to derive professional learning from their experiences in the work environment and aligning their actions to those of others (Costello, 2005; Miller, 2010).

This description shows how these two early discourses have similarities to the current dominant discourses of standardisation and diversity (Frost & Regehr, 2013). The discourse of standardisation with its focus on order and set end points can be linked to structural functionalism and the discourse of diversity with its celebration of individuality and difference, linked to symbolic interactionism. Similarly other

discourses have been named in medical education with an *objectifying* discourse being predominantly positivist and a *humanizing* discourse mostly interpretivist (Cribb & Bignold, 1999).

This gap between structural functionalism and symbolic interactionism was widened in the 20th century by the publication of two studies addressing the process of medical socialisation from differing viewpoints. The first study by Robert Merton and colleagues (1957), *The Student-Physician* described students at Cornell Medical school from a structural functionalist perspective. Whereas the study by Howard Becker and colleagues (1961) *Boys in White* considered the process of medical socialisation at the University of Kansas Medical school from a symbolic interactionist perspective.

Merton (1957) proposed a theory of medical socialisation on the basis of new recruits adopting 'the values and attitudes, the interests, skills and knowledge' of the group that they wish to join by a process of social reproduction (Merton, *et al.*, 1957 p. 287). He felt that the socialisation process into becoming a doctor was a linear one achieved by time spent at medical school (*ibid.*). However, his belief that behavioural norms were passed down to students to maintain stability, has since been critiqued as an overly conservative approach, with the reality being more complex (Brosnan & Turner, 2009).

In contrast Becker (1961), relates his study of medical socialisation to the individual student experiences and how they create and construct meaning through an interactive process. Becker thought medical school was an 'unreal world' where students devoted much of their energies to adapting to becoming medical students, rather than doctors and learning how to navigate the course (Becker *et al.*, 1961). From Becker's perspective, students were mostly learning how to impress their lecturers and collaborating to decide how hard to work (Brosnan, 2009).

The analytical schism

These two studies initially generated a healthy debate which has been described as the 'backbone of the sociology of medical education' (Jenkins *et al.*, 2021 p. 256).

However, the debate later intensified into something Hafferty (2000) has termed an 'analytical schism' (Hafferty, 2000 p. 241). Sociologists argued about whether knowledge was created through the underlying *structure* of institutions and group processes or by the individual *agency* and social interactions (*ibid.*).

The arguments between the paradigms had several subsidiary effects, which are often cited as reasons for the reduction in theory driven educational research (Brosnan & Turner, 2009). Structural functionalism was the initial dominant paradigm leading to the low status of social sciences within medical schools. The call for increasing performativity in health care meant that research focused on improvements in health and doctor training at the expense of social theory (Vinson, 2021). In addition, early sociological studies such as Goffman's (1961) *Asylums* were often critical of the medical profession and so ignored by senior doctors (*ibid.*). These incidences all acted to minimise the role of symbolic interactionism and the discourse of diversity.

However, structural functionalism became criticised as a paradigm since it did not allow for variation or human agency and assumed that the environment delivered the same outcomes for all (Costello, 2005). Symbolic interactionism notionally became the dominant paradigm by the 1980s, however this only marginally improved the situation regarding educational research. The focus was now given to medical student socialisation in individual medical schools without considering the wider social world they inhabited (Light, 2008). Bloom (1988) suggested one explanation may be the highly funded clinical research agenda which resulted in medical schools being unwilling to examine or change their underlying practices. Although medical schools appeared to be undergoing constant improvements to the curriculum and pedagogy, very little in fact altered; a case of 'reform without change' (Bloom, 1988 p. 295). This is an early example of the hidden curriculum at work and I have experienced this chairing the curriculum review at my own medical school. Although the university leads insisted that medical education was valued, more time and effort was spent by the institution pursuing research grants rather than improving the pedagogy.

This dichotomy between the paradigms interrupted the development of socially based medical education research for about 20 years and led to many calling medical education an atheoretical discipline (Bloom, 1988; Brosnan & Turner, 2009; Light, 1988). Very few qualitative studies since the 1980s have looked beyond individual medical schools to the wider national and international perspectives of medicine in society. This may have a bigger impact on medical education than other areas of social practice as discussed by Brosnan and Turner (2009), who view medical education as,

‘a crucible in which many of the questions central to sociology come to the foreground’ (Brosnan & Turner, 2009 p. 2)

Two further ethnographies of medical education were published in the United Kingdom; *The Clinical Experience: The Construction and Reconstruction of Medical Reality* based on first year medical students in Edinburgh (Atkinson, 1981) and *Making Doctors: An Institutional Apprenticeship* looking at medical student experience in one London medical school (Sinclair, 1997). Although Sinclair, in particular, makes efforts to link his findings to social theory, and cites Bourdieu in his analytical framework, the studies are largely placed in a symbolic interactionist framework and consider agency without structure. This schism between the two paradigms therefore continued throughout the 20th century (Vinson, 2021).

Current place of medical sociology

Despite many calls for a return to medical education research based in a sociological tradition (Albert *et al.*, 2007; Cribb & Bignold, 1999; Gill & Griffin, 2009, Rees & Monrouxe, 2010), there are signs 20 years on that this is slow to materialise (Hodges, 2020; Jenkins *et al.*, 2021; Vinson, 2021). Although numerous peer reviewed papers have been published together with a book *The Handbook of the Sociology of Medical Education* (Brosnan & Turner, 2009), research often mentions social theory in passing and does not identify a conceptual framework (Brosnan, 2013).

There has been a drive by medical educators to induct others in sociological methods with a series in *Academic Medicine* on the use of social theory (Hodges & Kuper, 2012; Varpio & MacLeod, 2020). Hodges (2020) does admit to an improvement saying,

'I suspect there is a larger audience than three decades ago prepared to accept me saying that I believe there are no fixed truths in medical education; that every 'truth' is a product of the place and historical era in which it is uttered' (Hodges, 2020 p. 691).

However, there are still tensions between research for medical education *producers*, aimed at increasing knowledge within the field and research produced for medical education *users* or applied research (Hirshfield, 2021). Sociology of medical education is therefore at an interesting point and is still struggling with the prominence of the competing paradigms (Hodges, 2020). Having considered the background to medical sociology and how the competing paradigms have arisen, I will now consider the sociological basis for identity development particularly looking at protected characteristics, and the sociology of professional identity development.

Identity and identity development

This section considers social theories behind identity and professional identity formation and how aspects of identity formation may be influenced by protected characteristics. It goes on to look specifically at medical professional identity and how views of this have been affected by the competing paradigms.

Before considering professional identities, we need to understand the broader process of human interaction in the world and how identities are formed (Monrouxe, 2016). Jenkins (2014) suggests identities develop in three distinct but interrelated world orders, 1) the *individual* order (internal psychological-cognitive world) 2) *interactional* order (relationships between individuals) and *institutional* order (interactions at the level of the organization). These theories are complex and are

often dependent on overlapping research paradigms. Theories about individual order identity may originate from a psychological tradition such as those proposed by Erikson (1959) and Marcia (1966) or from a social tradition such as those proposed by Mead (1934) and Blumer (1969). Broadly speaking, psychosocial identity theories focus on internal psychological processes and the linear path to a final product, often linked to crises (Vignoles *et al.*, 2011). Social and socio-cognitive theories are more concerned with how the individual interacts with the social world to socially construct an identity (Mclean & Syed, 2015).

In both traditions, individuals develop a primary identity at a young age, as they understand themselves as separate to others and become embodied individuals (Jenkins, 2014). At this time, they become aware of selfhood and additional factors such as gender, ethnicity and race. These primary identities are relatively stable throughout life and can be linked to Bourdieu's concept of habitus (Bourdieu, 1990a; Murphy & Costa, 2015). Many identity theories then see adolescence as the next main period of development with the process of *identity cohesion versus role confusion* continuing until the early twenties when most people gain an *identity achievement* (Erikson, 1968).

This has a significance for medical students arriving at university, as it is likely that their individual order identities will continue to be formed alongside their professional identity. Some believe that medical students have already developed a measure of professional identity even before arriving at medical school as a form of *anticipatory socialization* (Cavenagh *et al.*, 2000; Harvill, 1981). A prior knowledge of doctors from their daily lives coupled with a need to moderate their behaviour to gain a place at medical school, means that some applicants can already partially demonstrate the values and attitudes of a doctor. Hilton and Slotnick (2005) term this *proto-professionalism* and see this as a stage *en route* to full professional identity. In my conversations with medical students who have newly arrived at University, some already hold a view on what being a medical professional entails, but this is highly variable.

Following on from identity theories aligned to the individual order, students further develop their identity in the interactional order, and being linked to a medical school facilitates this process (Monrouxe, 2016). Students can now position themselves in relation to others and through language and acts, make sense of their identity including the values and morals they hold (*ibid.*). The interactional order is explained by narrative processes linked to social constructionism where students use discourse to construct and re-construct their developing identities (Monrouxe, 2009; Monrouxe & Rees, 2012). It is at this point that they are likely to experience identity dissonance due to messages delivered by the hidden curriculum (Hafferty, 2016) and due to the competing discourses of standardisation and diversity mentioned above (Frost & Regehr, 2013). It is also here that they can practise their developing identities through Goffman's dramaturgical theory of impression management (Goffman, 1959).

Interactions at medical school also take place as part of the institution and there is some overlap with identities developed as part of the institutional order (Monrouxe, 2016). Institutions are subject to power and hierarchy particularly demonstrated around areas such as the importance given to research (Albert *et al.*, 2007; Bleakley *et al.*, 2011), and this can affect developing professional identities. The institution is also a place where the effects of the hidden curriculum will be felt, for example in the emphasis of certain aspects of the curriculum such as science or surgery and the impact this may have on the students' development (Hafferty, 2000). The effect of an institution on a person's identity can be explained by *social identity theory* (SIT) that proposes a person's sense of who they are depends on the groups to which they belong. (Tajfel & Turner, 1979). Once we place ourselves in a particular group, we then make comparisons between other groups to define the 'in-groups' and 'out-groups' (*ibid.*). Social identity theory has been widely applied to the socialisation process in medical education as a means of describing social processes that occur at both the individual and group level (Burford, 2012; Goldie, 2012).

It is important to look at identity development from all three orders to consider different aspects of the same phenomenon. According to Nasir and Saxe (2003 p.16)

identities do not exist solely in the individual but are 'negotiated in social interactions that take form in cultural spaces'. Therefore, identity needs to be seen as an interaction between the *personal, relational and collective* identities in a social space (Vignoles *et al.*, 2011). Unfortunately, most empirical research is conducted by considering only one social order with little overlap (Jenkins, 2014). When considering race, ethnicity and gender, the individual aspects are considered more often than the social context of the identity development (Hammack, 2015; Quintana, 2007). This study is therefore considering identity formation in all three orders of social space as well as looking at certain protected characteristics. In the next sections, I discuss the social aspects of identity formation in relation to race, ethnicity and gender and the intersectionality between these protected characteristics.

Racial and ethnic identity development

The study of race and ethnicity identity development holds some complexities. The specific characteristics of race and ethnicity contribute to multiple identities yet may not be explicitly identified by the individual as part of their identity development. This is possibly because society is often not aware that the norms we internalise regarding race or ethnicity are actually social constructs (Anderson, 1983; Segal, 2010; Vignoles *et al.*, 2011). For example, someone may assume an identity of being British or being white, and not realise that these are social constructions invented by discourse in society (Helms, 1990; Vignoles *et al.*, 2011).

There are also concerns that ethnic identity research often employs stereotypes or shared storylines about ethnicity (Way & Rogers, 2015). These stereotypes are geographically specified and do not consider the historical and cultural basis of racial and ethnic views (*ibid.*). For example, an individual may identify as black, but they will have a different experience growing up in a city in the United States compared to a rural location in the United Kingdom (Quintana, 2007; Way & Rogers, 2015). This has implications for my research, as this study has taken place at a time of heightened awareness about racial discrimination in our society, as mentioned above. However, the site of the research at two contrasting medical schools may

offer differing perspectives and I have needed to ensure that I am not adopting mainstream cultural stereotypes to interpret participants' views.

This study is particularly concerned with the ethnic identity development of adolescents at the point they arrive at medical school. Most empirical research shows that young people from ethnic minorities tend to have a period of exploration in adolescence around their ethnic identity (Phinney, 1989; Seaton *et al.*, 2006; Yip *et al.*, 2006). There are two proposed benefits from developing a strong racial and ethnic identity in adolescence, to (i) foster identification and a positive affiliation with a racial group and (ii) to prepare an individual for discrimination.

The first benefit is generally easier to demonstrate. Young people from minorities holding a positive identification with their ethnic group have been found to have higher self-esteem (Whitesell *et al.*, 2006), a higher grade point average in college (Ong *et al.*, 2006) and lower levels of depression and stress (McHale *et al.*, 2006; Seaton *et al.*, 2006). However, the assumption that having a strong racial identity will prepare the young person for future discrimination is more complex (Quintana, 2007). Greene and colleagues (2006) found a period of ethnic identity exploration made individuals more vulnerable to the effects of discrimination. They suggest that the process of exploring one's identity may make individuals more aware of difference. Once the adolescents had gained an ethnic identity achievement they were relatively protected from the effects of discrimination (Greene, *et al.*, 2006).

There have been many studies on the exposure to early discrimination and its effect on the development of racial and ethnic identity. Evidence from longitudinal studies has shown that early exposure to discrimination is more likely to lead to an enhanced racial and ethnic identity, when previous identity levels are controlled (Pahl & Way, 2006; Sellers & Shelton, 2003). However, there is also research that suggests discrimination may lead to victimization and that this enhanced victim sensitivity (see p. 151) can lead to behaviours often labelled as low level concerns such as poor attendance and delays in communication with Faculty. At an extreme, this victim sensitivity may even be a factor in subsequent underachievement of ethnic minorities

(McWhorter, 2003, Worrell, 2015). These findings are relevant to my study since the participants reported many incidents of discrimination as part of their experiences and it is likely that this was affecting their identity in some way. The next section discusses the development of gender identity and the intersectionality with other identities.

Gender identity development and intersectionality

Original theories of gender identity development tended to be divided between the *gender constancy* theories derived from cognitive processes and first described by Lawrence Kohlberg (1966) and the *gender schema* theory introduced by Sandra Bem (1981) that suggests children develop a gender identity through a desire to conform to society's expectations of that gender. However, there is a constant flux of these societal expectations, highlighted by the changing nature of feminist theory and recent rise of queer theory and gender fluidity (Gauntlett, 2002). The frequent changes in discourse in societal views of gender mean that the process of gender identity development can be poorly understood (*ibid.*). Gauntlett goes on to state,

'Identities are not fixed – neither to the body nor to the self. We can perform gender in whatever way we like' (ibid., p.151).

One way of describing development of gender identities in these circumstances is to turn to the narrative theories based on the work of McAdams (1993) as these 'personal narratives both embody and create identity' (Fivush & Zaman, 2015 p. 34). The act of listening to others' narratives and sharing our stories about ourselves leads to the construction of a *gendered narrative identity (ibid.)*.

However, gender may not be the primary identity of a working professional who is likely to hold multiple identities (Hammack, 2015; Monrouxe, 2010). Gender should not be considered as an individual attribute but be looked at via the process of *intersectionality* methodology (Monrouxe, 2014). Intersectionality is an analytical

framework for understanding how aspects of a person's identity combine and overlap to create different networks of discrimination and privilege (Crenshaw, 2016).

Intersectionality is defined as 'both a theory and research methodology that emphasizes categories of difference' (Crenshaw, 2005). It is based on the premise that gender and racial identity and other characteristics are not manifested independently but interact together in temporally and spatially defined social spaces (Tsouroufli *et al.*, 2011). Tsouroufli and colleagues have gone on to critique various studies (Babaria *et al.*, 2011; Haq *et al.*, 2005; Lee & Coulehan, 2006) where the impact of gender and ethnicity on medical students have been considered as independent variables without drawing on intersectionality (Tsouroufli *et al.*, 2011).

We hold multiple identities that are continually forming and reforming through the narratives and discourses that we share in a constructionist process (Monrouxe, 2014). Although this individual-in-context perspective is often considered to be the fundamental interpretation of identity formation, there has been a criticism that empirical research in the past 40 years has tended to focus on only the individual or the interactional aspects and not a combination (Way & Rogers, 2015). This lack of integrated research may be particularly significant when considering racial and ethnic and gender identity formation where individual identities are subject to stereotypes and need to be seen in the context of a particular grouping (*ibid.*). The methodology and data analysis in this research allows me to consider identity in all contexts.

The next section discusses how professional identity is formed in professions in general, and then focuses on medical profession identity formation and how this has been affected by the competing paradigms in sociology.

Professional identity formation

Identity theories from the psychosocial tradition see occupational identity formation as a stage of maturation in adolescence where successfully selecting an occupation is integral to the formation of an achieved identity (Erikson, 1959; 1968; Vondracek

1992). More recently, the socio-cultural theories recognise that professional identity formation is a form of professional socialisation occurring at two levels, that of the individual and collective, involving,

‘Socialization of the person into appropriate roles and forms of participation in the community’s work’ (Jarvis-Selinger *et al.*, 2012 p.1186).

Many authors view professional socialisation as synonymous with professional identity formation (Cohen, 1981; Jenkins, 2014; Sadeghi Avval Shahr, 2019). However, Luke (2003) who used Bourdieu’s theories and the concept of habitus to inform her study of professional identity formation of junior doctors in Australia strongly rejects the term professional socialisation. She sees this term as attempting,

‘to fit medical students and current doctors into a certain trajectory of a single path of the goal to being ‘socialised’. (Luke, 2003 p. 49).

In her opinion, this term implies passivity of the individual and reproduction of the existing system and she prefers the term ‘professional development’. However, in this study I have chosen to follow the views of those who are considering both the individual and collective facets of socialisation, with Hafferty asserting that the ‘underlying dimension of socialization is personal transformation’ (Hafferty, 2006 p. 59).

When exploring other professions, there is a common theme that professional identity is enhanced by a sense of belonging and socialisation into the profession. (Levett-Jones & Lathlean, 2008; Zarshenas *et al.*, 2019). This is recognised with professions increasingly offering degree apprenticeship as a route to gaining full access to the profession (Casey & Wakeling, 2020; Higgs, 2021; Smith *et al.*, 2021). Apprenticeships, which are linked with the discourse of diversity, are an example of early immersion in a community of practice (Lave & Wenger, 1991) and are also thought to encourage social mobility (Smith *et al.*, 2021). However, this needs to be considered alongside the regulatory requirements demanded by the professions in order to be permitted to practice, the so-called *credential monopoly* (Olsen, 1983). Control by the regulatory bodies of those that can enter a profession is part of the discourse of standardisation and I have compared these aspects of the medical profession to some other healthcare professions in Table 2 below.

Table 2: Comparison of entry requirements, regulation and views on professional socialisation in selected healthcare professions

Profession	Length of study	Place of study	Degree Apprenticeship Available?	Regulation of education	Views on professional identity formation (PIF)
Dentistry	5 years BDS plus 1 year foundation training	University and embedded placements plus apprenticeship as a graduate	No. Only for linked courses such as dental nurse and dental hygienist	Qualified dentists must register with GDC to practice	<ul style="list-style-type: none"> PIF in dental students influenced by contact with patients and understanding of team roles PIF linked to developing ethical clinical practice (Bebeau, 2009; Morison <i>et al.</i>, 2011)
Medicine	5 years MBBS plus 2 years foundation training	University and embedded placements plus apprenticeship as a graduate	No. Although being considered	GMC accredited degree with Medical Licensing Assessment commencing in 2024/25	<ul style="list-style-type: none"> Concepts of PIF affected by competing discourses. (Cribb & Bignold, 1999; Frost & Regehr, 2013)
Nursing and midwifery	BSc 3 years	University and embedded placements	Yes	Nursing and Midwifery council approves programmes and registers nurses/midwives at the end of the course	<ul style="list-style-type: none"> Professional socialization enhanced by a sense of belonging. PIF related to motivation, knowledge acquisition and role models Midwives feel technology is eroding their PIF (Larsson <i>et al.</i>, 2009 ; Levett-Jones & Lathlean, 2008 ; Zarshenas <i>et al.</i>, 2014)
Pharmacy	MPharm 4 years plus 1 year foundation training	University plus apprenticeship as graduate	No. Only for pharmacy technicians not registered pharmacists	General Pharmaceutical Council (GPhC) accredited degree with registration assessment at the end of foundation training	<ul style="list-style-type: none"> Confused about their professional identity. Are they shop keepers or care givers? Thought to be due to non-pharmacy trained managers (Elvey <i>et al.</i>, 2013).
Social work	3 year BSc or 2 year MSC in social work	University	Yes	Registration by Social Work England	<ul style="list-style-type: none"> Socialisation to the profession occurs both before and after education phase in a process of pre-socialisation and professional practice (Miller, 2010)

Medical professional identity formation

'When the topic of professionalism arises, the clouds of confusion descend making difficult to see the landscape' (Irby & Hamstra, 2016 p.1606).

Medical professional identity is also affected by competing paradigms. The tensions between caring and detachment have probably been in existence in medicine since the early days of the profession but became more prominent with the Flexner reforms in the early 20th century (Cribb & Bignold, 1999). Abraham Flexner changed the way medical education was viewed in 1910 with a series of reforms which led to medicine becoming a university-based discipline with an emphasis on science (Dornan, 2005; Duffy, 2011). This stressed the importance of the scientific doctor capable of maintaining emotional distance and neutrality and linked to the discourse of standardisation (Cribb & Bignold, 1999; Frost & Regehr, 2013). The converse values are the humanising and caring aspects of being a doctor that are linked to the discourse of diversity (*ibid.*). Many feel that the focus on academia in medical education introduced by the Flexner reforms have led to a subsequent lack of importance given to subjects such as sociology and professionalism (Cooke *et al.*, 2006; Dornan, 2005; Duffy, 2011). Doctors in the 21st century are confused about their role and whether they are altruistic professionals held in high esteem (BMA, 2017), or more commonly seen to be providing a service in an increasingly democratised society (Tweedie *et al.*, 2018).

Until the end of the 20th century, medical professionalism was implicit and understood to be transmitted in an apprenticeship manner to medical students (Cruess & Cruess, 1997). Following on from the GMC's guidance document, *Tomorrow's Doctors* (1993), the teaching of professionalism at medical school became a part of the core curriculum with an expectation that professionalism should be taught and assessed as any other competency (Cruess & Cruess, 1997; Frank *et al.*, 2010). However, professionalism became subject to the competing paradigms leading to an initial confusion about what attributes should be both taught and assessed (Cribb & Bignold, 1999; Hodges *et al.*, 2011). This centred around whether professionalism is considered a set of specific actions to be followed (Cruess & Cruess, 1997) the so-called 'doing of professionalism', or whether it involves a

sociologically constructed change in persona, or professional identity formation the so-called 'being of professionalism' (Cruess *et al.*, 2016; Monrouxe, 2010).

The first discourse of 'doing' is based on 'competencies' and claims that in the age of patient safety, professionalism is a competence as any other, with a series of attributes that can be taught and assessed (Cruess & Cruess, 2010; Frank *et al.*, 2010; Lurie *et al.*, 2009). This is a compelling argument for the assessors who can easily design professionalism assessments around these competencies (Hodges *et al.*, 2010, Wilkinson *et al.*, 2009). This discourse of doing fits with the overarching paradigm of standardisation. However, competencies have come under attack by some educationalists, being termed a reductionist method to teach and assess professionalism (Frost & Regehr, 2013; Hodges, 2006; Hodges & Lingard, 2013). There is an argument that the choice of competencies is dependent on the current discourse and choosing to not assess certain parts of the curriculum can lead to the unintended consequence of incompetence in students (Hodges, 2006). Where professionalism is not specifically mentioned as a competency to be assessed, such as in an assessment blueprint, the medical students may feel this lacks importance and can be disregarded (Hodges, 2006, Hodges & Lingard, 2013). Although most agree that medical students need to demonstrate competence, this can take place in a 'tea-steeping' framework over a period of time, rather than a linear, outcomes based framework (Hodges, 2010).

The second discourse of 'being' asserts that professionalism is not a competence but context specific and created through social interactions. Becoming a medical professional can only be considered following a period of professional socialisation and the formation of a professional identity (Hafferty & O'Donnell, 2014; Hodges, 2006). Professional identity formation has now become the dominant discourse in medical professionalism with some key individuals changing their message from 'professionalism must be taught' (Cruess & Cruess, 1997) to 'reframing medical education to support professional identity formation' (Cruess *et al.*, 2016). There is now a wide literature base calling for professionalism to be viewed in the light of an identity formation in both medicine (Cruess *et al.*, 2016; Goldie, 2012; Jarvis-

Selinger, 2012; Monrouxe, 2010) and other healthcare professions (Levett-Jones & Lathlean, 2008; Miller, 2010; Zarshenas *et al.*, 2019). (See Table 2, page 43).

A third professionalism discourse that arose from the sense of outrage following the medical malpractice cases, was that of virtue-based professionalism. This has been described as a place where ‘lives of service are created and sustained’ (Daaleman, 2011 p. 327). Virtue-based professionalism is based on underlying character and a return to traditional values (Coulehan, 2005; Field & Scotland, 2005). Irby and Hamstra (2016) assert virtue-based professionalism focuses on,

‘The inner habits of the heart, the development of moral character ... plus humanistic qualities of caring and compassion’ (ibid. p.1606).

Often termed a nostalgic form of professionalism (Hafferty, 2016), this has been critiqued as a model due to the difficulties of teaching virtues to students (Coulehan, 2005). To medical students this version of professionalism may oppose the realities actually present in the learning environment and cause an internal conflict that further impedes professional learning (*ibid.*), being seen as ‘patronizing, old-fashioned, outdated, and unhealthy’ (Castellani & Hafferty, 2006 p. 20). However, virtue-based professionalism is championed by many (Daaleman, 2011; Huddle, 2005; Irby & Hamstra, 2016), with Irby and Hamstra (2016) giving it equal weighting alongside behaviour-based professionalism and professional identity formation, to be considered in their reframing of medical professionalism.

Expectation of competency is also at odds with another discourse in medical education about *training for uncertainty*. It is recognised that the practice of medicine is not wholly a positivist science with clear endpoints but contains many uncertainties around diagnosis, treatments and navigation of healthcare services (Fox, 2013). The GMC has recognised that physicians often need to make important decisions based on limited knowledge and the latest GMC guidance *Outcomes for Graduates* now includes outcomes on dealing with complexity and uncertainty (GMC, 2018a). However, there is limited advice about how to achieve this important learning objective. Both clinical uncertainty and professional uncertainty have been shown to

increase the amount of stress and burnout experienced by medical students and newly qualified doctors (Russel *et al.*, 2021). There is a suggestion that this may be another area that the medical students are able to navigate through social constructivism, and I return to this later in the discussion.

This section has shown how the competing paradigms have led to many different models and ways of viewing professionalism and the resultant tension between these discourses has contributed to the confusion that students experience about what medical professionalism entails. I propose one way to integrate these paradigms of professional formation is to draw on existing major 20th century sociological theories. In the past sociologists have either not specifically applied their theories to medical education (Bourdieu) or have described a concept rather than a unifying theory (hidden curriculum). Since this study is set in a social constructionist paradigm, it was important to base the analysis in social theory. In the next section, I discuss how Pierre Bourdieu's theoretical framework (Bourdieu, 1977) can be used to link the paradigms of structural functionalism and symbolic interactionism. I also discuss the dramaturgical theory of Erving Goffman (1959; 1961) demonstrating how the students may manage their developing professional identity through social constructivism.

Analytical framework

Framing the data analysis using sociological theoretical perspectives, helps to position this work in the dynamic social structures and descriptors of changing attitudes to medical professionalism, education and culture. (Vinson, 2021). I have chosen to analyse the data through the lens of Pierre Bourdieu's theoretical framework of *habitus, capital and field*. This theory can be used to draw together the contrasting paradigms by demonstrating effects of both structure and agency (Brosnan, 2009; Horvat, 2003). I will also draw on the *dramaturgical theory* of Erving Goffman originally described in *The Presentation of Self in Everyday Life* (Goffman, 1959) and impression management to explain how medical students are using social constructivism to define their professional identities. I discuss why I believe these

theories help to provide an overview of two contrasting paradigms and so lead to a better understanding of practices in the social world.

Pierre Bourdieu (1930-2002)

'The function of sociology, as of every science, is to reveal that which is hidden' (Bourdieu & Ferguson, 1998 p.17).

Pierre Bourdieu was a French philosopher who used the concepts of *habitus*, *capital* and *field* to describe social mobility, social class and the political influence of the state (Swartz, 1997; Thatcher *et al.*, 2016). According to Bourdieu (1977), the routine practice of individuals is determined by their *habitus* or the underlying norms and values that they have absorbed through their education and early life. Habitus is then influenced by a set of available resources that Bourdieu termed *capital*, which may be social, cultural, economic or political. Habitus and capital interact together in the dynamic external social world known as the *field* to produce practice (Thatcher *et al.*, 2016). Bourdieu argued that education, family and social class worked together to reinforce inequities in society in a process termed social reproduction (Bourdieu & Passeron, 1977). Bourdieu used his research on education to particularly demonstrate these systems of domination used to reproduce hierarchical structures in a field (Bourdieu, 1988; Bourdieu & Passeron, 1977).

The selection of Bourdieu's theory as an analytical tool can be considered on the basis of three underlying premises particularly relevant to this project, 1) the linking of theory to empirical research, 2) attempting to bridge the dichotomy between the paradigms, 3) using reflexivity at every stage to increase the subjectivity of the research (Horvat, 2003).

Linking theory to empirical research

The first premise is Bourdieu's linking of theory to practical research outcomes. As has been mentioned above, medical education research in recent years has often lacked an underlying conceptual framework and theoretical basis (Brosnan, 2013; Rees & Monrouxe, 2010). Bourdieu's approach was consistently to develop a

'theory of practice', driven by empirical research and using epistemological concepts to explain the complex social world (Grenfell, 2012a). He was not interested in theory *a priori*, describing other French approaches as 'pompously theoretical' (Bourdieu, 1990b p. 22). He commenced his research with a practical context and a social problem, such as the study of peasants in Algeria (Bourdieu, 1962). He then crafted a fusion of theoretical construction and empirical research observations, with a reflexive interplay between the two positions (Grenfell, 2012b). Bourdieu never intended his writing to stand alone but was keen to provide a template that could aid other researchers (Bourdieu & Wacquant, 1992; Wacquant, 1989).

Bridging the paradigms

The second underlying premise is an attempt to select a theory that will link the paradigms of structural functionalism and symbolic interactionism, with the divergent views on whether social change is most effected by structure or agency. Bourdieu's theory works well in this respect, since in *Practical Reason* (1998a) he encourages us to 'think relationally' about how habitus, capital and field interact to drive change in the social world. There is evidence that Bourdieu was aware of the effect of the competing paradigms in medical education since in *Homo Academicus* (1988) he describes a 'complex and multidimensional opposition' between the scientists and clinicians in the medical faculty (Bourdieu, 1988, p. 59).

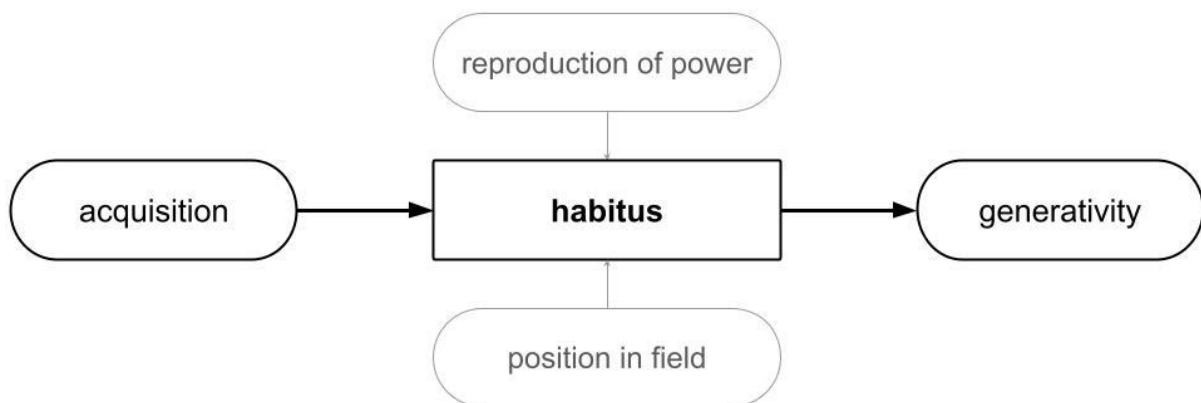
Habitus has been described as, 'systems of durable, transposable dispositions' which are formed and function within a social field (Bourdieu, 1977 p. 72). Habitus, which is at the heart of Bourdieu's theory, is formulated by early family life experiences and is subject to change as one progresses through life. One of the important features of habitus is that it is embodied in an individual and not simply the result of thoughts and feelings (Reay, 2004). This will be important when considering the construct of *medical habitus* discussed below.

There has been much discussion about whether habitus is something experienced at the conscious level or something acting inherently and below the level of our understanding (Luke, 2003; Noble & Watkins, 2003; Reay, 2004). Bourdieu's early

work (Bourdieu, 1984; 1990a; Bourdieu & Passeron, 1977) was keen to stress that habitus was an unconscious embodiment of dispositions in the field, however this has been criticised as too deterministic and not making allowances for individual agency (Noble & Watkins, 2003; Reay, 2004). Bourdieu allowed the inclusion of a cognitive element to habitus in his later work (Bourdieu, 1998b), and many sociologists working with habitus consider that it has both unconscious and conscious elements (Luke, 2003, Reay, 2004).

In this later view, habitus goes onto structure educational experience, which in turn may change the habitus and generate future experiences (Bourdieu, 1977). Therefore, in addition to confirming one's position in the field via social reproduction, habitus also goes onto generate future habitus and structures, therefore linking the concepts of structure and agency (Swartz, 1997). These four aspects of habitus are represented diagrammatically below (Fig 1).

Fig 1: The four aspects of habitus (from Noble & Watkins 2003 p. 525).



When considering how **capital** functions in the field to shape habitus, Bourdieu mentions economic, social, cultural and symbolic capital that all interact to produce influence in a field (Bourdieu, 1984). Symbolic capital can be defined as the honour or recognition given to someone by virtue of their position or title (Grenfell, 2012a).

Or as Bourdieu says,

'Symbolic capital is a credit; it is the power granted to those who have obtained sufficient recognition to be in a position to impose recognition'
(Bourdieu, 1989 p. 23)

The power generated by capital is *misrecognised* by participants in the field as actual power, when it is in fact a social norm. These misrecognised social norms then serve to reinforce the habitus in a process termed *symbolic violence* (Bourdieu & Wacquant, 1992). Symbolic violence differs from true violence since it is often 'exercised upon a social agent with his or her complicity' (*ibid.* p.167). An example might be where a woman colludes with a man to agree that they are the weaker party. Often none of the individuals in a field are aware of the symbolic violence which is played out through taken for granted social norms (Schubert, 2008). This has relevance when considering socio-economic class and education as in this study. For example, in *Homo Academicus*, Bourdieu comments that trying to explain the reduced higher educational uptake of lower socio-economic classes by blaming this on their poor academic performance, is actually a form of symbolic violence that reproduces the social hierarchies (Bourdieu, 1988).

The **field** is an important area of Bourdieu's theory often ignored in empirical research in favour of habitus and capital (Horvat, 2003; Brosnan, 2010). Bourdieu (who uses the French word *champ* meaning battlefield, rather than word *pré* meaning an agricultural field) thought of the field as a dynamic area or forcefield (Bourdieu & Wacquant, 1992). This is the arena where all interaction takes place and players adopt dominant or subordinate positions dependent on the amounts and types of capital they can access (*ibid.*). Importantly individuals can be part of many fields or subfields at any one time with the definition of what counts as legitimate capital varying between fields (*ibid.*). Brosnan (2010) uses Bourdieu's concept of field to discuss the place of medical education with the medical schools representing individuals competing for different forms of capital including economic capital and

symbolic capital conferred by league tables and research status. This concept of fields and sub-fields is discussed further in the methodology chapter 4 p. 83.

Need for reflexivity

The third underlying premise is Bourdieu's requirement to use reflexivity at every stage of the research to avoid objectivism and to question the social norms (Deer, 2008; Swartz, 1997). This is particularly relevant for this study being performed in a social constructionist paradigm. Bourdieu wrote about social realities that went unquestioned because 'the tradition is silent not least about itself as a tradition' (Bourdieu, 1977 p.167). He termed these shared beliefs that lay beyond any notion of enquiry, the *doxa* of the field and felt this was responsible for the reproduction of practices in the field (*ibid.*).

However, reflexivity is not only an issue for participants but also for social science researchers embedded in their subject matter. Bourdieu felt strongly that as researchers in our own field of academia, we need to consider the accepted norms and our positionality within that field to avoid unthinking reproduction of the *doxa* (Bourdieu & Wacquant, 1992).

'What distresses me when I read some works by sociologists is that people whose profession it is to objectivize the social world prove so rarely able to objectivize themselves and fail so often to realize that what their apparently scientific discourse talks about is not the object but their relation to the object' (Bourdieu quoted in Wacquant, 1989 p. 33)

Bourdieu's three-level methodology, discussed below, introduces reflexivity at every stage in an attempt to address this effect (Bourdieu & Wacquant, 1992).

Applying Bourdieusian theory to modern research

Bourdieu researched widely in education, with both school and higher education underpinning much of his research output (Murphy & Costa, 2015). Many researchers have applied his theory to explain social practices and inequalities present in education (Bowers-Brown, 2016; Murphy & Costa, 2015; Reay *et al.*,

2005). However, a lack of rigour in social science research where individual aspects of the theory are often used to reify concepts, has led to some researchers claiming that Bourdieu is applied to empirical research as a form of 'intellectual hairspray' (Reay, 2004 p. 432). Recent champions of Bourdieu stress that it is necessary to consider all the elements of the theory (habitus, capital and field) when doing a Bourdieusian analysis (Grenfell, 2012b; Thatcher *et al.*, 2016).

Bourdieu is sometimes critiqued for a concentration on social class with a rare mention of gender, race, sexuality and other protected characteristics (Horvat, 2003; Sayer, 2005). Although, he does address ethnicity, migration and displacement in his classic study *The Algerians* (Bourdieu, 1962), he often represents France as ethnically undifferentiated and has been called 'race-light' in his analysis of social factors (Wallace, 2016 p. 38). Bourdieu has also been critiqued by feminists for assuming a masculine-dominated habitus (Lovell, 2000). However, the theory of embodied habitus interacting with capital in a field encompasses all aspects of the social world, and this will include gender and race (Rampersad, 2015). Reay (2004) argues that through his extensive writing, Bourdieu has been considering dominant and non-dominant groups in society, and that gender and race would have been included implicitly. As Bourdieu writes in *Distinction*,

Gender properties are as inseparable from class properties as the yellowness of a lemon is from its acidity' (Bourdieu, 1984 p.107).

Recently Bourdieusian theory has been used to look at racial and ethnic identities of black Caribbean schoolchildren in London (Wallace, 2016), the educational choices of girls (Bowers-Brown, 2016) and the underachievement of Afro-Trinidadian boys at primary school (Rampersad, 2015). There is also an argument that by considering the interaction between the various forms of capital as 'intersecting multiple capitals' (Warin, 2015 p. 41), Bourdieusian theory can be utilised to operationalise intersectionality between gender, race and social class (Bowers-Brown, 2016; Friedman & Laurison, 2019; Woodward, 2018).

Medical habitus

Bourdieu did not focus on health in his research and made no explicit study of medical education (Cockerham & Scambler, 2010). However, other researchers have used his theories to discuss medical professional socialisation and the specific *medical habitus* that can be created at medical school (Sinclair, 1997; Brosnan, 2009; Luke, 2003). Sinclair's ethnographic study *Making Doctors* (1997) looked at student socialisation in one London medical school and was the first researcher to use the term medical habitus drawing on the work of both Bourdieu and Goffman (Brosnan, 2009). Sinclair defined medical education as the acquisition of a set of specific dispositions, such as being scientific and caring, which then formed the medical habitus (Sinclair, 1997). Since medical students often practiced their clinical skills on one other before examining patients, they were also physically embodying the habitus (*ibid.*).

Some of Sinclair's dispositions may be more commonly linked to capital than habitus, such as the *disposition of knowledge* and of *status* (Brosnan, 2009). However, he was the first researcher to point out a theoretically driven reason for the emotional dissonance that the students experience in the clinical environment. Like Becker *et al.*, (1961), he noted that students' dispositions centred around becoming competent rather than caring, however this was at odds with the idealism the students held on entry to medical school (Sinclair, 1997). Since, these dispositions were embodied as part of their habitus, and in his view, not present at a conscious level in the students, they were unable to reflect critically on the conflicting positions (*ibid.*). I found this application of Bourdieu's theory particularly useful to explain the challenges faced by 'students in difficulty' at my medical school. This helped to demonstrate why students found it so hard to amend their behaviour, even when provided with full support by the faculty, as these dispositions were deeply embedded in their original habitus.

Students are often not able to articulate the internal conflict at witnessing challenges to their habitus, but describe themselves as 'becoming disillusioned, harder and

more cynical' (Sinclair, 1997 p. 303). This increase in cynicism is well known in medical education and is thought to lead to stress, burnout and deteriorating mental health amongst students (Awad *et al.*, 2019; Kachel *et al.*, 2020; Wear *et al.*, 2006). More recently, the effect of this dissonance has been linked to moral injury or the psychological distress people experience when reality does not match deeply held beliefs (Dean *et al.*, 2019; Murray *et al.*, 2018). The terms moral injury and burnout are sometimes used interchangeably, but moral injury is often the preferred term as this 'locates the source of distress in a broken system and not a broken individual' (Dean *et al.*, 2019 p. 401). I too have witnessed many students experiencing deteriorating mental health but never before considered that its roots may lie in challenges to deeply held values and beliefs.

There is an increasing literature about the necessity for medical students to be more resilient to cope with threat of burnout (McKinley *et al.*, 2020; Zwack & Schweitzer, 2013), with the GMC introducing it into their guidance for medical students, *Achieving good medical practise* (GMC, 2016a). However, it seems that this is derived from the discourse of standardisation with the competing discourse of diversity suggesting that increasing resilience amongst students may lead to an erosion of empathy (Hojat *et al.*, 2009; Oliver, 2017). Requiring students to be resilient in their medical degree means they may blame themselves for not being tough enough if they subsequently encounter difficulties in their studies (*ibid.*).

The development of resilience in medical students can be seen to have both negative and positive connotations. Resilience may be detrimental, leading to adverse mental health outcomes, if the students are using it to suppress dissonance and adopt a habitus set out by the competing discourse. However, it may also have positive effects if the students are using resilience to actively develop an alternative professional persona to manage their dissonance.

Use of Bourdieu's theory with its incorporation of the relatively durable habitus helps to explain why the negative experiences of medical students may lead to dissonance and moral injury. Such negative experiences are not only challenging their beliefs,

but also their underlying identity and innate sense of who they are as developing professionals. This makes Bourdieu's theory particularly appropriate to explore the experiences of culturally diverse students as they forge a professional identity as doctors.

However, although Bourdieu's theory can describe the nature of the experiences of the medical students and the reasons for their expressed dissonance, I was keen to use a theory more based in agentic change to discuss how the students deal with these experiences. I found the dramaturgical theory of Erving Goffman particularly useful at this point and was encouraged by the fact that this theory has been employed by other researchers discussing medical professional socialisation (Sinclair, 1997, Monrouxe *et al.*, 2009). Bourdieu is thought to have been influenced by the work of Erving Goffman (Jenkins, 2014; Swartz, 1997) and I discuss the link between the two researchers and Goffman's theories in the section below.

Linking Bourdieu and Goffman

Erving Goffman was a Canadian sociologist who made a lasting contribution to the field of sociology through the lens of symbolic interactionism or the everyday interactions that symbolise daily life. Bourdieu is thought to have been particularly influenced by Goffman's concept of *total institutions* referring to mental hospitals and originally described in *Asylum* (Goffman, 1961; Swartz, 1997). Goffman described such institutions as any place of work or living, separated from wider society and developing its own set of social norms (Giddens, 2018). The concept of total institutions have also been linked to the closed hierarchical social systems present at medical school (Hafferty, 2016; Lempp, 2009). It is possible to see how Bourdieu might relate total institutions to his concept of field. He is also thought to have adopted some of these more agentic concepts, as a means of resisting the French structuralism views prevalent at that time (Swartz, 1997). Bourdieu particularly liked aspects of Goffman's dramaturgy theory and the improvisatory nature of the interactions occurring in the field (Jenkins, 2014). Therefore, it seems appropriate to link Bourdieu and Goffman in the data analysis for this study.

Erving Goffman (1922-1982)

Goffman is probably best known for his dramaturgical theory originally described in *The presentation of self in everyday life* (Goffman, 1959). From his empirical research, Goffman uses a metaphor of the stage to explain how individuals interact in standard social events, including performers, directors and the audience (*ibid.*). He noted that individuals differed in the way they acted when being seen by others or when interacting in a closed group and he termed these frontstage and backstage activities (*ibid.*). Goffman studied both verbal and non-verbal interactions and noticed on the frontstage, individuals tended to over communicate aspects that depicted them in a better light and under communicate those aspects that they wished to conceal (Lewin & Reeves, 2011). The frontstage performances were more formal and considered, with the individuals employing *impression management* in their interactions to control the way they were seen by others (*ibid.*). The backstage performances were generally relaxed and informal but often used as a way to rehearse or plan the frontstage activities (*ibid.*).

Goffman enlarged on this theory and discussed different types of impression management in his later work (Goffman, 1963; 1967). In *Stigma* (1963), Goffman discussed how individuals managed stigmatised identity such as a minority or a disability and were influenced by the societal definition of that identity. They used *information control* as a form of impression management to select the parts of that identity that they are willing to disclose to others (*ibid.*). In *Interaction Ritual* (1967) individuals took part in *defensive* mechanisms as part of saving face or *protective* mechanisms carried out to prevent others from losing face (*ibid.*). The application of these theories is relevant to how the participants in this study managed their identities whilst carrying the perceived stigma of an ethnic minority or belonging to a lower socio-economic group.

The concept of impression management has been used widely in healthcare settings to describe the performance of doctors (Broadhead, 1983; Ellingson, 2005; Lewin &

Reeves, 2011), medical students (Becker *et al.*, 1961; Sinclair, 1997) and nurses (Melia, 1987). Monrouxe and others (2009), use Goffman's theory to analyse the involvement of patients in bedside teaching of medical students. They describe the difference between the manner and language of the senior doctor talking to the patient on the ward round (frontstage) and then talking about the patient to the medical students (backstage) (*ibid.*). This is something that I have observed in my medical education practice and also in my previous research regarding clinicians assessing medical students for professionalism in clinical settings.

Patel and others (2018) discussed how surgical residents in Canada used impression management to portray an image of competence in the workplace. The surgeons were following a sociocultural expectation to present as proficient surgeons and to ensure that they matched an ideal surgical stereotype. They stated that,

'The difference between how we think we should feel and how we actually feel creates a tension that prompts us to manage our image, to create the impression we want others to see' (Patel *et al.*, 2018 p. 769).

The researchers expressed some concerns that the lack of authentic frontstage performances could have consequences for the residents' learning, as they would be less willing to ask questions that might display their lack of knowledge (*ibid.*). I am also familiar with this in my own medical setting where students may be unwilling to ask questions of a lecturer or consultant for fear of showing their ignorance. This is one argument for the introduction of near-peer teaching alongside consultant-led teaching, as students may be less concerned about impression management and keener to ask questions (Bowyer & Shaw, 2021).

Sinclair (1997) used and adapted Goffman's theory in his ethnographic study of medical students, *Making Doctors*. He also described frontstage and backstage areas of activity in the institution of the medical school but divided these into official and unofficial areas, and additionally presented an offstage area or lay world. Frontstage activities could either be official curriculum events such as ward rounds and lectures or unofficial events such as sports matches or theatrical performances. The official backstage activities he defined as the hidden curriculum, and the

unofficial backstage activities where there was preparation for the front stage as areas such as the student bar (see Figure 2 below).

Fig. 2. The institution described in terms of stages, from Sinclair, 1997 p16.

	OFFICIAL	UNOFFICIAL	LAY WORLD	OFFSTAGE
FRONT STAGE	Formal and informal curriculum Lectures, ward rounds, examinations	Games field e.g., rugby, football Theatrical performances		
BACK STAGE	Hidden curriculum	Preparation for frontstage activities e.g., student bar		

Lewin and Reeves (2011) built on this work of Sinclair when examining interprofessional teamwork in a hospital based setting. They defined the activities as planned, ad hoc or offstage and found that effective teamworking occurred more frequently in ad hoc backstage activities than planned frontstage activities. However, the backstage activities such as corridor conversations allowed the frontstage activities, such as conversations in front of a patient to occur as a form of impression management (Lewin & Reeves, 2011).

From these examples, it can be seen that these backstage activities are typical of those usually ascribed to the hidden curriculum such as corridor conversations or the culture of an institution transmitted via social activities (Hafferty, 1998). However, according to Goffman and others, these backstage processes are necessary to rehearse the responses that individuals want to present to others on the frontstage as a form of impression management. Medical students are therefore performing social interactions in the backstage environment in order to inform how they will present themselves on the frontstage as a form of social constructivism.

There has been further discussion about the motivation of medical professionals employing impression management and whether this is in itself professional or denotes a lack of integrity. The debate about whether medical professionalism is something that becomes embodied in an individual or is simply a series of actions has been described above. Hafferty sums this up with the following 'Do we want physicians who are professional, or will we settle for physicians who can act in a professional manner?' (Hafferty 2006, p. 283). Goffman discusses how performers may misrepresent facts but says they are often reacting to social pressures without even being aware they are putting on a performance (Goffman, 1959). Patel and others (2018, p. 773) explain this by saying that the hidden curriculum makes surgical residents 'behave in ways that are against their own moral code'.

There is a sense that the discourse of competency and the resulting high stakes environment may lead to trainees feeling forced to misrepresent themselves on the frontstage (Huffman *et al.*, 2020). It seems that it is often the dissonance between what students or doctors are expected to do and what they are able to do that forces this frontstage performance and I will return to this issue of whether this should be deemed professional in the discussion chapter.

This chapter has considered the historical basis in sociology for the competing paradigms and explored how these have affected identity and medical professional identity formation with a resultant confusion in what is expected of the medical students. Identity development as it relates to protected characteristics is particularly relevant to this study as these diverse students may be subject to aspects of the competing paradigm at medical school as they negotiate their professional identity formation. In practice, the teaching and assessment of medical professionalism contains elements of all discourses, and the lack of concordance may contribute to the uncertainty students feel about their developing professionalism (Frost & Regehr, 2013; Irby & Hamstra, 2016).

One way of linking these competing paradigms has been suggested by using the theories of Bourdieu and Goffman that allow for a consideration of how capital

influences habitus in the field. The dissonance students feel when presented with situations that are in conflict with their underlying values, can be framed in Bourdieu's concept of habitus. Students experience this dissonance as moral injury and find the conflict difficult to process since it is attacking their own embodied identity. Goffman's theory of impression management shows how agency allows students to use social constructivism to negotiate their developing professional identities across the paradigmatic divide.

In the next chapter, I discuss two current manifestations of the tensions between competing paradigms, that of hierarchy and the drive to widen participation and how the hidden curriculum, present at all levels of medical education is often responsible for delivering these conflicting messages.

Chapter 3 - Current tensions between the discourses

In the previous chapter I discussed the theoretical basis of the competing paradigms and how the use of social theory of Bourdieu and Goffman could be used to combine the paradigms. This chapter focuses the argument closer to my topic of empirical study by exploring the literature surrounding two of the main manifestations of the competing discourses in medicine; that of the hierarchical structure of the medical profession which stems from the discourse of standardisation, and that of widening participation which is driven by the discourse of diversity. It also explores the hidden curriculum which is responsible for delivering many of the messages from the opposing discourse, often leading to the dissonance and moral injury experienced by medical students.

Hierarchy in medicine

‘Subservience or deference to a perceived superior can be a particular barrier when issues arise among healthcare professionals about a colleague’s performance. Not only does it make it difficult for an individual to summon up the courage not to conform, but this sense of hierarchy also influences who gets listened to within the organisation when questions are raised’ The report into children's heart surgery at the Bristol Royal Infirmary 1984-1995: learning from Bristol (Kennedy, 2001 p. 269)

Hierarchy in the medical profession is an example of enactment of the discourse of standardisation. It is particularly relevant to this study since hierarchies affect the experience of all students but may have a greater impact on the culturally diverse students (Frost & Regehr, 2013). The medical profession is known to be especially subject to hierarchy or a rigid power structure (Bleakley *et al.*, 2011; Lempp, 2009). This has remained largely unaltered in the past 150 years despite wide ranging societal changes (Lempp, 2009) and calls to ‘flatten the hierarchies’ (Green *et al.*, 2017; Whitelaw *et al.*, 2020). Hierarchies are present in many forms in medicine including the perceived superiority of some specialties over others, the influence of the research lobby in institutions of education, and the power afforded to consultants in the hospital medicine structure.

To understand the rise of the power of professions it is useful to examine Foucault's analysis of the emergence of clinical medicine in the 20th century (Foucault, 1973; 1977). In *The Birth of the Clinic*, he shows how the use of discourse allows a move from *sovereign* power to *disciplinary* power based within social institutions such as hospitals (Foucault, 1973). *The Birth of the Clinic* introduces the concept of the *medical gaze*, which was a new way of understanding illness and led to a shift in how doctors were perceived (*ibid.*). Foucault describes through various discourses of power, the way medicine is performed, and how relationships are constructed between doctors, patients and students (*ibid.*). In *Discipline and Punish* (1977), Foucault further explores the concept of power and how it forms professional discipline through institutional practices. In this model, power does not reside in an individual but is capillary and flows through a system in a manner determined by the discourse (Hodges *et al.*, 2014). In Foucault's view, discourse is not socially constructed between individuals, but is influenced through a series of wider social and political changes, which shape what is allowed to be spoken and enacted at a particular time (Foucault, 1972). Without an *epistemological rupture* or far reaching societal differences to allow for a change in discourse, medicine is unlikely to allow for alterations that will threaten its power base (Foucault, 1977; Luke, 2003).

Looking at the classic profession of medicine, the contract with society gave doctors autonomy to self-regulate and set up an organisational structure loosely based on the apprenticeship model (Monrouxe & Rees, 2017). Following the Flexner reforms, doctors maintained a system of hierarchies in an attempt to preserve the *status quo* (Walton, 2006). However, the relationship between consultant and junior, intended to mirror that between master and apprentice, became more akin to superior and subordinate, than to teacher and learner (*ibid.*). The system in place is designed to preserve the power of consultants, with senior experienced registrars being termed 'junior doctors' until they achieve consultant status (Ratcliffe, 2012). It is recognised that the hierarchical system risks patient safety, with juniors being unwilling to challenge seniors to point out errors (Bould *et al.*, 2015; Green *et al.*, 2017). The need for senior doctors to provide a reference for the trainee's next job has led to an

unwillingness to speak out and an 'unhealthy obsequiousness' (Walton, 2006 p. 229).

The presence of damaging hierarchies may also have contributed to the malpractice scandals such as the failings of Mid Staffordshire Trust (Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013) and the Bristol children heart surgery deaths (Kennedy, 2001). This inquiry found that the higher incidence of mortality could be traced back to an imbalance of power in the institution, with 'too much control in the hands of a few' (Kennedy, 2001 quoted in Brennan & Davidson, 2019).

Medical students become aware of the hierarchies in medicine at an early stage in their training where they may be introduced to teaching by humiliation (Crowe *et al.*, 2017; Lempp & Seale, 2004). This includes events such as being singled out on a ward round or asked to perform intimate examinations without consent on anaesthetised patients (*ibid.*; Monrouxe & Rees, 2017). I have heard many examples of these in my teaching practice with students. This is often delivered by the tacit values of the hidden curriculum (Cribb & Bignold, 1999; Lempp, 2009) with medical students realizing that 'career progression was in many ways dependent on their capacity to tolerate and accept humiliation and intimidation' (Crowe *et al.*, 2017 p. 71). These incidences, experienced more often in the clinical environment, are at odds with the teaching delivered in the medical school and lead to the dissonance mentioned above (Monrouxe & Rees, 2017). These everyday experiences were the type of event I considered in my interviews with the participants.

There have been efforts to improve the situation with an encouragement for doctors to raise concerns by linking this to the doctor's professional duty and patient safety (GMC, 2012). The GMC has published a *Professional Duty of Candour*, which both encourages honesty with patients and a means for staff to raise concerns about colleagues. (GMC, 2015). However, whistleblowers often do not feel able to raise concern without fear of retribution (Bolsin *et al.*, 2011; Monrouxe & Rees, 2017). The Francis report found that there was a culture of fear that prevented staff from raising concerns (Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013). Medical

students are similarly unwilling to report concerns, with one study finding only 13% of students would report a senior doctor at the start of the course with this proportion dropping to 5% by the end of the course (Goldie *et al.*, 2003). This mirrors my experience in medical education where students are encouraged to report adverse events they may have witnessed through a Datix reporting system, but in practice rarely do this. The fewer numbers willing to report by the end of the course may relate to concerns about the senior doctors being responsible for their accreditation.

It seems that the persistence of hierarchy in medicine emanates from the discourse of standardisation and the desire for the senior doctors to impose a form of control they feel has been eroded by the managerial system. According to Foucault (1977), the dominant discourse will persist until there has been an epistemological rupture that allows for a change in the way the world is viewed. In recent years, the discourse of diversity has been trying to effect this change and attempt to defuse the hierarchies with the introduction of the duty of candour and a no-blame culture. (GMC, 2015). Although all NHS Trusts are required to have a means to raise concerns and a whistleblowing policy (*ibid.*), evidence remains that enacting this policy on the ground is much harder, and the discourse of standardisation is remaining dominant.

Having looked at an example from the discourse of standardisation, I will now examine in more detail in the next section the drive to broaden the make-up of the medical student population as an example from the discourse of diversity.

Increasing diversity in medical schools

The process in medical schools known as *widening participation* (WP) is an example of a policy from the discourse of diversity. In the past 30 years, there has been a move to increase the diversity of graduating doctors to mirror the population they are serving. Medical schools have been tasked to broaden their selection of students to include more female students and those from lower socio-economic and ethnic minority backgrounds.

One of the factors limiting diversity in the medical profession is the propensity for social reproduction or *heritability* within the profession. The tendency for children to follow the profession of their parents is known as micro-class reproduction (Weeden & Grusky, 2005). Medicine is described as one of the most heritable of professions. Data from the Labour Force Survey compares the professions of individuals with their parents and shows that those whose parents are doctors are 24 times more likely to be doctors than people whose parents did any other type of work (Friedman & Laurison, 2019). This same report showed that individuals were 17 times as likely to follow parents into the law profession and only twice as likely to become accountants if the parents were in this profession, showing that medicine has high levels of heritability compared to other professions (*ibid.*). These findings are also apparent in other European countries, where between 12 and 16% of medical students had one parent who was a doctor (Hansen, 2005; O'Neill *et al.*, 2013).

The WP strategy has been largely successful in terms of female students and some BME groups -notably Asian, but much less so in terms of lower socio-economic classes (Apampa *et al.*, 2019; Patterson & Price, 2017) and Black Caribbean students (Gamsu & Donnelly, 2017). This has led Social Mobility Foundation chief executive David Johnston to state 'the balance has tipped only slightly – towards privately educated non-white males'. (BMA, 2015).

A BMA report entitled *The Right Mix* (2015) has noted that 80% of medical students come from 20% of secondary schools and that between 2009 and 2011, half of all schools in the UK did not provide a single applicant to medicine (*ibid.*). It goes onto state,

'The struggle for social mobility within the profession is still in its infancy, although the chief obstacle is not so much outright opposition as inertia' (BMA, 2015).

Despite calls from the Office for Students and Medical Schools Council (MSC) to drive the change, with most medical schools having WP programmes, the current

state of play has been described as 'non-committal' (Apampa *et al.*, 2019 p. 921). With an apparent resistance to change it is appropriate to closely examine the rationale behind the motivations and the power dynamics that may be underlying the failed efforts (Razack *et al.*, 2015). One of the issues is a lack of agreement about the meaning of widening participation. In the UK this refers almost exclusively to social class (Apampa *et al.*, 2019) whereas in the USA the focus is on improving racial and ethnic diversity (Krstić *et al.*, 2021). Any intersectionality between these characteristics is not further considered and this confusion is likely to be contributing to the resistance to change.

A recognition of the need for a diverse medical profession has been present since Flexner wrote,

'We have no right... to set up standards which will close the profession to poor boys' (Flexner, 1910 p. 42).

The earlier discourses were motivated by a drive for racial equality and social equity and a desire to right the wrongs of society (Frost & Regehr, 2013; Nivet, 2011). However, this discourse of diversity was soon overtaken by the need to achieve excellence. For example, in USA after Flexner, a call to support highly performing medical schools led to the closure of the African American and women's medical school (Hodges, 2010).

In effect, there was little difference in the composition of the medical workforce until the broader societal changes occurring from the 1970s onwards. Freidson's (1970) work *Professional dominance: the social structure of medical care* pointed out the inequities and there was a call to proletarianise the medical profession (McKinlay & Arches, 1985). The diversity discourses in the past 30 years have been based on a need to diversify the profession to train doctors who will better represent the society they are serving, in the interest of improved patient outcomes (Frost & Regehr, 2013; Garlick & Brown, 2008). Diverse students will,

'bring to their training a multitude of different talents, unique outlooks, and distinct experiences, which enhance the educational experiences of all

medical students, and thus serve to engender more culturally competent, empathic, and service-oriented graduates who are better prepared to care for society's increasingly heterogeneous patient population' (Frost & Regehr, 2013 p. 1571)

There is some evidence that training with students of other backgrounds brings educational benefits and increased student empathy (Whitla *et al.*, 2003). This has meant diversity no longer needs to be in opposition with excellence, by asserting that diversity can contribute to better doctors (Nivet, 2011). However, this discourse is not embedded in core processes, particularly the admissions process with its drive to competitively select the most academic students (Razak *et al.*, 2015). Medical schools although nominally supporting widening participation with outreach activities for schoolchildren are retaining their right to select students on the basis of excellence (Apampa *et al.*, 2019). Beagan (2000) writes about the professional socialisation process in Canada acting to neutralise the existence of social differences amongst the medical student population. This is my experience where summer schools are designed to ensure the applications of WP students mirror those of the mainstream students. The WP agenda at the admissions stage is therefore left with tensions between the discourse of diversity and standardisation (Frost & Regehr, 2013).

The experience of diverse students once they are admitted to medical school is rarely considered as schools are keen not to stigmatise these students by specifically monitoring their progress (Apampa *et al.*, 2019). However medical schools in the US have noted a higher rate of student attrition from lower socio-economic groups (Brewer & Grbic, 2010), with one study finding students who had grown up in low income neighbourhoods having a 40% higher chance of not progressing at medical school than other members of the cohort (Nguyen *et al.*, 2022).

The next sections now consider in more detail the intersectionality of social class, race and ethnicity and gender on increasing diversity in the student population and the discrimination often experienced by students who enter medical school with

these characteristics. I am not considering other protected characteristics such as religion, disability or sexuality since although these will impact the cultural experiences of the students, they are not generally part of the WP discourse and were mentioned only rarely in the data collected from the participants in this study.

Socio-economic class

Currently drives to widen participation in the UK usually refer to aiming to increase the numbers of students from a lower socio-economic class (BMA, 2015). In 2012, a report from the Social Mobility and Child Poverty Commission highlighted that medicine had fallen behind other subjects in ensuring fair access (Cabinet Office, 2012). This led the MSC to set up the Selecting for Excellence project in 2013 stating, 'multiple data sources should be used to construct a definition of a widening participation background' (MSC, 2014).

The BMA defines widening participation as 'a government initiative offering opportunities to groups of people who are under-represented in higher education'. In their view these under-represented groups have lower socio-economic status but not different races or ethnicities (BMA, 2020a).

Socio-economic class in young people can be difficult to define, as will be discussed in the methodology chapter. It is often described by using occupation type and income, but students are not part of the workforce. The MSC report uses data from four main themes: 1) *identity* (age, gender, ethnicity, disability), 2) *family background* (National Statistics Socio-Economic Classifications (NS-SEC), Parental experience of higher education, Household income indicators) 3) *Neighbourhood* (Index of Multiple Deprivation (IMD), POLAR 4 data, Region) and 4) *Educational context* (Type of school) (MSC, 2014).

The Index of Multiple Deprivation (IMD) and POLAR 4 data are also known as postcode data. POLAR is an acronym which stands for *Participation Of Local AREas* and divides the UK into 5 quintiles comparing the proportion of young people in each

area that enter higher education. It is much criticised since both the postcode data and university entrance data is out of date (Lenon, 2020). School data may be inaccurate as many young people, particularly those aspiring towards a career in medicine may change school for 6th form studies.

The MSC states there has been improvement in diversity in the last 5 years with an increase in admissions of 35% from the lower POLAR quintile, 46% from the lower IMD quintile and 14% from state schools (MSC, 2020). However, the majority of medical students still originate from private schooling and the higher social classes (Apampa *et al.*, 2019; Steven *et al.*, 2016).

It is unclear how to encourage admission of students from lower socio-economic groups as a number of studies showed a sense of feeling unsuitable for medicine is rooted deeply in their aspirations and narrative about their lives (Greenhalgh *et al.*, 2004; Gore *et al.*, 2017). This represents the *habitus* that they have developed from their early life and schooling (Bourdieu, 1977). With the non-committal stance from medical schools mentioned above, it has been suggested that contextual admissions with students from WP backgrounds offered lower grades may be the only way to widen access to medical school (Cleland *et al.*, 2018). However, for others from the discourse of standardisation, this approach is controversial with the effects being unproven and concerns voiced about lowering standards (Frost & Regehr, 2013; Patterson & Price, 2017).

It is also unclear if students from lower socio-economic groups are given enough support on arrival at medical school (Krstić *et al.*, 2021; Patterson & Price, 2017). It is not straightforward to track these students as they progress through medical school as they may be less willing to admit to class differences. A systematic review by Krstić *et al.*, (2021) on 27 WP studies found that most data related to ethnic minorities rather than social class. There are few studies on medical students experiencing discrimination solely due to class although in Canada, Beagan (2005) suggests that students may be subject to 'everyday classism'; a form of micro-inequity at medical school. She gives examples where students feel uncomfortable

by not being able to talk about the right sort of sports or holidays when chatting in the operating theatre (Beagan, 2005). Bourdieu terms this group as 'excluded from the inside' since they were admitted to medicine, but not fully included in it (Bourdieu, 1999 p. 618). In addition, the working class students often felt more isolated once at medical school due to an anti-elitist stance from family and friends at home (Beagan, 2005). Having considered social class, I will now move on to discuss race and ethnicity and medical students' experience of racism.

Race and ethnicity

Prior to the 1970's most medical students in the UK were white and male with the number of non-white medical graduates numbered at 2% in 1972 (Goldacre *et al.*, 2004). This picture has changed, and currently medical schools have a higher BME intake than many other institutions in the UK with about 40% of students admitted to medical school each year being of BME origin compared with 22% attending other higher education courses (GMC, 2016b; Kmietowicz, 2020). However, non-white ethnic minorities are overrepresented in all higher education courses (Modood, 2004), and I will discuss the possible reasons for this below. In the last five years since the publication of the Selecting for Excellence report, there has been a 29% increase in medical students from a BME background (MSC, 2019b). Due to the increasing numbers of international medical graduates, the number of ethnic doctors in training is even higher with 47% of licenced doctors identifying as non-white (GMC, 2020).

These numbers alone could make medical schools complacent that we have succeeded in achieving racial diversity at medical school and in the profession as a whole, but the true story is more complex. Most of these BME students are represented by South Asians, with black males being particularly underrepresented (MSC, 2019b). In 2014 only 0.3% of the intake to medicine and dentistry in the UK were from black Caribbean families (Gamsu & Donnelly, 2017) and in 2017 only 270 black students were admitted to UK medical school on a standard entry course compared with 1970 Asian and mixed heritage students (MSC, 2019b).

There is also the issue of differential attainment, where students from BME backgrounds perform less well than their white colleagues in university examinations (Dillner, 1995; Woolf, 2020). This difference is seen in written and practical assessments across many medical schools (Haq *et al.*, 2005; Woolf *et al.*, 2013) and is even present in machine marked multiple choice exams, leading to questions about possible causation (Woolf *et al.*, 2011). After controlling for possible examiner bias, and prior education level of the BME students, there are questions raised that this ethnic gap may be related in some way to the student-teacher relationship (Woolf, 2020). A suggestion had been made from research on African American students in the United States that they perform less well in their assessments due to the fear of negative stereotyping internalised during their teaching (Steele, 1997). Woolf and others (2008) found evidence of negative stereotyping towards Asian students, but it is not known if this, or other effects of discrimination experienced during their time at medical school are causing the attainment gap (Woolf, 2020).

Racial discrimination is widely prevalent at medical school with a 2019 report into UK universities finding that a quarter of BME students had experienced racial harassment on their course (Equality and Human Rights Commission, 2019). A BMA survey of its members in 2018 found that a third of BME medical students felt that bullying and harassment were a problem in their medical school, a similar proportion to all students. However, the BME students felt less confident to speak up and report the abuse (BMA, 2018). The British Medical Journal (BMJ) used the whole edition to discuss racism in medicine in February 2020 (Adebowale & Rao, 2020) and expressed their disappointment that an issue raised in the journal more than 25 years previously, remained a problem. Matters were intensified by an escalation of the Black Lives Matter protests following the killing of George Floyd by police in the USA in May 2020 and many medical students felt newly empowered to speak out (Gera, 2020).

Medical students also discuss discriminations delivered by *microaggressions* or 'subtle insults (verbal, non-verbal and/or visual) directed against people of colour

often automatically or unconsciously' (Solórzano *et al.*, 2000 p. 60). They have been described as a form of 'everyday racism' or series of practices that are seen as normal by the dominant group (Beagan, 2001). Microaggressions may be intended as a compliment, such as saying African American people are a credit to their race. (Sue & Spanierman, 2020). Espaillet *et al.*, (2019) looked at the incidences of microaggressions in one US medical school and found that 54% of respondents (n=351) had experienced a microaggression. Microaggressions are thought to more closely reflect underlying societal norms than incidences of outright racism although they may also lead to overt aggression (Sue & Spanierman, 2020).

Although the volume of discourse around racial discrimination has recently increased, it is not clear what the profession can do to reverse these changes. Medical schools have been asked to sign up to the BMA racial harassment charter developed as an attempt to address the discrimination experienced by BME medical students in the UK (BMA, 2020b). Many academic institutions and medical schools are *decolonising* their curricula to remove colonial references and a Western white bias and make teachers and students aware of unconscious biases. (Gishen & Lokugamage, 2019). Although laudable, there is a sense that due to the hierarchies in medicine and hidden curriculum that the profession does not really want to change. It is possible that this study looking at the issue from the view of the students experiencing discrimination and how they combat this, may offer another perspective. Having considered race and ethnicity, I now move onto discussing the impact of gender on WP together with incidences of sexism.

Gender

Prior to the societal changes that arose in the 1970's, medicine was a male-dominated profession. Becker (1961) was able to talk about *Boys in White*, despite 5% of the student body being female (Beagan, 2001). Merton (1957) described a medical school as a place 'to give him [sic] the best available knowledge and skills' (Merton *et al.*, 1957 p. 7). Even in 1997, Sinclair's ethnographic study reported student experiences from the rugby club and student bar and while discussing

discourses of power relating to gender, barely mentioned the experiences of female (or ethnic minority) students (Sinclair, 1997; Lempp, 2009).

Year on year, the number of female medical students rose to a high in 2004, when women represented 60.5% of those entering medical school (Moberley, 2018). The most recent MSC *Selection Alliance* report shows 59.7 % of the students commencing medicine in 2017 were female (MSC, 2019b).

Female numbers rose in medicine due to a drive for gender equality, as every other profession but the reason for these particularly high numbers is thought to be due to a discourse known as the *feminisation of medicine* (Riska, 2009). This discourse arose around 2000 and characterised the increasing numbers of women in medicine as inevitable due to their increased empathy and holism (*ibid.*). Since women are perceived to be more caring, they are entering medicine in high numbers, and there are concerns that this may be coupled with causing a reduced status effect of the medical profession (Bailey, 2020). This discourse then problematises increasing women in medicine due to reduced resilience, retention and economic effects (Riska, 2009). Since women have more childcare responsibilities and may leave the profession early, it has been suggested that this could precipitate a workforce crisis (McKinstry, 2008).

The large number of female medical students does not fully translate into the same proportions in the workforce where only 37% of consultants are female compared to 56% of general practitioners (Michas, 2021). Amongst the specialties there is marked difference with female specialists over-represented in paediatrics and obstetrics and gynaecology but under-represented in surgery (Dacre & Shepherd, 2009; Moberley, 2018). This suggests there is not yet true equality in medicine and may be either because women are socialised into choosing certain professions within medicine or that there is a glass ceiling preventing women from succeeding in certain career areas (Riska, 2009). The suggestion that certain female orientated specialities may have lower status is summed up by Amanda Howe, quoted in Roberts, 2005,

'It is interesting that having a high proportion of women in a particular specialty is often associated with that specialty losing its high status and popularity. Why? Why is 'being attractive to women' apparently unattractive for men?' (Roberts, 2005 p.13).

In addition, there are many reports in the medical literature of medical students experiencing sexual harassment during their training often in the form of 'micro-inequities' or microaggressions (Beagan, 2001; Espaillet *et al.*, 2019). For example, addressing a mixed class with 'Good morning, gentlemen' or assuming male students were doctors whereas female students were nurses (*ibid.*). Some students described witnessing discrimination of this nature as triggering 'professionalism dilemmas' (Monrouxe & Rees, 2017). In a study of 230 students at one UK medical school, 40% medical students had experienced or witnessed inappropriate touching, gestures, or advances from healthcare professionals (Brill, 2016).

Clearly although we have moved on from *Boys in White*, we are some distance away from true gender equality in medicine with fewer women as Deans of medical schools or holding senior clinical leadership positions (Bailey, 2020). We need to move beyond the discourse of the problem of women in medicine to enable to women to flourish in the specialty of their choice (Dacre, 2008). I have considered the individual themes of social class, race and ethnicity and gender in detail as cultural aspects that affect the diversification of entry to medical school. I will now look at the interaction between these cultural aspects termed *intersectionality*.

Intersectionality

Intersectionality is a term that arose in the feminist movement and was conceptualised by the writer Kimberlé Williams Crenshaw in 1989. It is an analytical framework for understanding how aspects of a person's identity combine and overlap to create different networks of discrimination and privilege (Crenshaw, 2016). It is important because the presence of some identities such as for example, female gender and BME ethnicity can be compounded and cause a much greater disadvantage than that experienced by one group alone (*ibid.*).

For example, intersectionality has been found to be a significant factor for students who leave medical programmes early. Nguyen and others (2002) looked at the attrition rate of 37,000 medical students in the US, from the viewpoint of three marginalised identities: race and ethnicity, family income and under resourced neighbourhoods. After adjusting for academic achievement, they found there was a higher incidence of attrition from medical school with an increased number of co-existing marginalised identities.

Intersection of race and socio-economic class is widely studied in education; however, it is not always a compounding of protected characteristics that leads to the biggest disadvantage. White working class boys have been known for some time to perform relatively poorly at school, compared to other demographics, with only 10% of the most disadvantaged white males progressing to higher education (Hillman & Robinson, 2016). The reasons for this are unclear but it is worth noting that references to lower academic achievement and reduced aspirations on the part of white males (Baars *et al.*, 2016) are seen by Bourdieu to represent symbolic violence (Bourdieu, 1988). By this he means ascribing something that is a socially constructed norm and responsible for reproducing the doxa in the field as an independent variable.

The intersection of race and ethnicity with socio-economic class and gender is rarely considered in medicine and is not discussed in the MSC data although they note briefly 'that there is an overlap between some BME backgrounds and being from a lower socio-economic background' (MSC, 2019b p. 6). However, this is oversimplifying a complex issue, as some BME backgrounds are associated with a lower socio-economic class with others being associated with a relatively high socio-economic status coupled with a high work ethic, and a drive to enter the professions (Wilson *et al.*, 2011). In one medical school study, students from the lower socio-economic classes were up to 100 times less likely to enter medical school than students from the higher classes but having an Asian background led to an up to ten times mitigation in this effect (Seyan *et al.*, 2004). The intersection of being from a

lower socio-economic group and Asian therefore led to a different entry rate to medical school compared to either group alone.

One explanation for the over representation of Asian students in medicine is that students from an immigrant background are drawing on *ethnic capital* which may lead to a drive to succeed that transcends social class origins (Modood, 2004). Career choice is affected by parental aspirations leading to an increased higher education application rate from some ethnic minorities even after accounting for academic achievement and school factors (Wilson *et al.*, 2011).

It is important to look at multiple factors when considering WP and increasing the diversity of the medical school intake, even though this adds to the complexity. What seems to be clear, although WP sits within the discourse of diversity, efforts to fully enact these changes are blocked by the discourse of standardisation. This leads to the inertia around embracing difference or for example, introducing contextual admissions through a reluctance to lower standards. Also, where medical schools may be keen to act, there may be resistance from other areas of the profession such as the male-dominated consultant body.

I have discussed how hierarchies and efforts to widen participation at medical school are examples of the two opposing discourses, but within each example there are attempts from the other discourse to shape the agenda and change the outcome. Some of these conflicting meanings will not be explicit but will be delivered through the hidden curriculum where encountering these contradictory messages can lead to confusion and dissonance, and I discuss this in more detail in the section below.

Hidden curriculum

'Ignoring the hidden curriculum...will continue to risk reform without change...the equivalent of moving the deck chairs around on the Titanic'
(O'Donnell, 2014 p. 15).

As mentioned above, the hidden curriculum is often responsible for much of the dissonance that the students experience from trying to negotiate the competing paradigms of standardisation and diversity. It is present in all aspects of medical education, including at the institutional level, and therefore, it is necessary to consider the impact of the hidden curriculum to give an overarching view of the medical socialisation process.

The hidden curriculum is a term that has been used since the 1960's in sociology and education but was first linked to medical education in the work of Frederick Hafferty and Ronald Franks (Hafferty & Franks, 1994). They refer to the hidden curriculum as an underlying culture in medical school and suggest that 'most of the critical determinants of physicians' identities lie not within a formal curriculum, but a more subtle "hidden curriculum"' (*ibid.* p. 861). Much of what is learned at medical school, including professionalism, is not transmitted by the *formal* or written curriculum, but by the *informal* or ad hoc curriculum (conversations between students and teachers outside the timetable) and the *hidden* curriculum. The *hidden curriculum* is a 'set of influences that function at the level of the organizational structure and culture' (Hafferty, 1998 p. 404). These are the unstated, tacit rules that signal to the student 'this is the way we do things around here' (*ibid.*).

Through the dissonance experienced by medical students, the hidden curriculum may lead to a medical socialisation process occurring mostly at the interpersonal level (Brosnan, 2009). However, the hidden curriculum does not only deliver negative messages (O'Donnell, 2014). Role models are commonly cited as an example of a beneficial aspect of the hidden curriculum and thought to be responsible for teaching much of professional identity as well as influencing career choice (Lempp & Seale, 2004; Hafferty & Castellani, 2009).

The hidden curriculum also functions at the institutional level and social structure and organisational culture have been shown to have additional impact on changing values (Hafferty, 2000). Hafferty suggested four particular areas when considering the hidden curriculum at institutional level; 1) policy development 2) evaluation 3)

resource allocation and 4) institutional 'slang' or nomenclature (Hafferty, 1998). Examples where organisational structure and culture dominate at a hidden curriculum level are the amounts of physical space in a building and the timing and scheduling of junior doctor rotations, giving trainees a clear message about what is valued by the faculty (Christakis & Feudtner, 1997). According to Hafferty (2000),

Within... these routines, acceptable definitions of reality are constructed, power relationships reproduced, and the nature, content and pace of work imbued with moral meaning (ibid. p. 244).

Hafferty has linked the medical school culture to that of *total institutions* described by Goffman (1961) in *Asylum* (Hafferty, 2016). Cruess and Cruess feel that some degree of 'isolation with like-minded individuals' is necessary to allow the process of enculturation and professional identity formation to take place (Cruess & Cruess, 2014). However, it is possible to see how such a closed institution could become a place of stress and unhealthy isolation delivering negative messages via the hidden curriculum.

Hafferty argues that one of the main causes of curriculum reform without change is that reforms target the formal curriculum only, leaving the hidden curriculum unaddressed (Hafferty, 1998; 2000; Hafferty & Castellani, 2009). Changes are therefore made to the outward structure of the curriculum without considering the underlying social norms. One example given is the rise of the professionalism teaching agenda at medical school. Schools state that professionalism and communication are at the forefront of their teaching and place professionalism in the formal curriculum. Yet the assessments, such as the forthcoming Medical Licensing Assessment (MLA), remain focused on scientific and clinical knowledge and so students continue to deem professionalism to have a lesser value (Good & Good, 1993). Indeed, the fact that professionalism is often termed a 'soft' skill and so not worthy of serious study, is a hidden curriculum element that adds to this trend (Lafleur *et al.*, 2019).

Hafferty (2000) warns against thinking of medical education as the formal transmitting knowledge versus the hidden curriculum transmitting values since the reality is more complex. He prefers to consider medical education as a complex system of interwoven formal teaching, opportunistic teaching and the effects of culture which occur in every interaction and in every setting (Hafferty & Castellani, 2009; Hafferty & O'Donnell, 2014). He gives as an example the prominence of the scientific research agenda mentioned in *Homo Academicus* and cited above (Bourdieu, 1988). Science teaching will be prominent in the formal curriculum and may be present in the informal curriculum by for example discussion about the number of papers 'needed' for postgraduate application. Medical students will see its presence in the hidden curriculum by the presence of award ceremonies or ease of promotion by which the students learn about the importance of scientific research. In this way, the discourse of standardisation may deliver messages via the hidden curriculum about the importance of research (Albert *et al.*, 2007; Hafferty & Castellani, 2009).

Studying the hidden curriculum is complex because it is by definition hidden, and uncovering it is likely to reveal other hidden attitudes, sociocultural norms and practices (Hafferty & Castellani, 2009). According to Hafferty and Castellani (2009 p. 33) 'there is always a latent to every manifest, an informal to every formal and/or a back stage to every front stage'. Simply to expose the hidden curriculum and make these factors known, may have unintended consequences. For example, trying to harness the power of role models as mentors, often leads to a different interaction with the student, as the role models may not be aware they are being viewed in this way (Hafferty & Castellani, 2009). However, there is a value in trying to improve our understanding of how a student's professional identity is formed and 'closing the gap' between what is being taught and what is actually learned by the students (O'Donnell, 2014 p.1).

From the examples mentioned above, it can be seen how the hidden curriculum can present factors from the opposing discourse to undermine intended change. Most often it will be residual effects from the discourse of standardisation linked to power

and research funding that may erode valiant efforts from the discourse of diversity. For example, efforts to introduce a no-blame culture and Duty of Candour (GMC, 2015) may be limited by seeing the impact of whistleblowing on individuals and the need for a reference from seniors. Efforts to increase the diversity of the medical profession are limited by an unwillingness to change standards and the experiences of discrimination that culturally diverse students have on entering the medical profession.

Summary

This chapter has highlighted some of the issues present in the field of medical education in the UK and shown how they are dependent on the competing discourses. Doctors are unsure about the role they are expected to play in society; that of the omniscient scientist or caring practitioner. The autonomy of the medical profession is under threat and to some extent maintaining the hierarchical structure from the discourse of standardisation allows doctors to feel they retain some control. The discourse of diversity is driving the WP agenda, but this is only partially succeeding at increasing the diversity of intake to medical school due to conflict with the discourse of standardisation. Where there is an increase in diversity such as high numbers of women or Asian students, then there is either overt discrimination or the discourse moves to problematizing the situation, as in the workforce crisis caused by the numbers of women in medicine. The hidden curriculum is often presenting the opposing discourse to the students and creating a dissonance which may be particularly acute for diverse students as they feel that their underlying habitus is under threat. This chapter has summarised the empirical field in which this research project has taken place and gives the background for the experiences related by the participants. In the next chapter, I discuss the methodology that I have chosen to use to explore how these culturally diverse students forge their professional identities in this environment.

Chapter 4: Methodology and research design

The literature review chapters have explored the literature around cultural aspects of medical professional formation in the competing paradigms. In this chapter, I discuss the methodological principles that underpin this study and how these have been influenced by my previous research experience and the research questions I am attempting to answer. I present the formation of my philosophical principles in the presence of competing paradigms and how these principles have shaped the theoretical concepts that have driven this research with the reflexivity that I have applied at every level. I additionally demonstrate reflexivity by considering the ethical principles that have underlined this research. I show how the philosophical principles and research questions have driven the research design, methods and data analysis of this study so demonstrating epistemological integrity (Marshall & Rossman, 2006).

Philosophical principles

In this section, I explore my understanding of research paradigms and my prior experience throughout my career as a doctor and then educationalist. I discuss how I came to choose a particular research paradigm and methodology for this study. I consider my exposure to the competing paradigms and explore why there may be a *false dualism* in the understanding of this debate (Pring, 2015).

There are many ways of seeking to understand the world and these are described as paradigms. A paradigm is defined by Thomas Kuhn (1962) as 'the set of common beliefs and agreements shared between scientists about how problems should be understood and addressed' (Kuhn, 1962 p. 23). A paradigm is a way of looking at the world, deciding what problems are to be investigated and how knowledge is acquired, and this is closely linked to the *ontology and epistemology* (Cohen *et al.*, 2017).

Ontology is the study of being or existence (Blaikie, 1993) and is often described with two contrasting approaches; the *realist* approach that suggests we as researchers exist independently from the world we are trying to study and the *relativist* approach that suggests researchers are inextricably linked with the field of research (King & Horrocks, 2010). Epistemology is the philosophical theory of knowledge and 'way of establishing not only how we know what we know, but what counts as knowledge' (King & Horrocks, 2010 p. 8). A realist ontology tends to link with an epistemology that the world can be defined, measured and often described in numerical terms. A relativist ontology links with an epistemology that reality cannot be pre-defined but needs to be interpreted (Cohen *et al.*, 2017).

Many research paradigms have been described and are usually characterised into the two broad categories of *positivism* and *interpretivism* (Pring, 2015). The positivist paradigm follows a realist ontology and takes a view that there is an objective reality that can be known and defined. Research often follows hypothesis testing and is carried out using quantitative methods. The interpretivist paradigm follows a relativist ontology and believes that reality is socially constructed and is usually carried out using qualitative methods with meanings constructed and negotiated between the researcher and participant (Cohen, *et al.*, 2017).

Pring (2015) however, discusses the risk of oversimplifying these competing paradigms into a false dualism (Pring, 2015 p. 59). It is not possible to fully reject positivism in favour of interpretivism as the discourses in which we form a socially constructed reality are themselves only possible through a stable and enduring understanding of the boundaries of reality (*ibid.*). While positivist research will not actually deliver the 'truth' and is in fact a *naïve realism*, interpretivist research, is dependent on realist ontology to deliver its socially constructed outcomes (*ibid.*). This is significant for the paradigm wars mentioned above, as these two positions thought to be diametrically opposed are likely to have more overlap than previously considered. This will be discussed further in the reflexivity section below.

As a medical doctor I was trained in the positivist paradigm for nearly 20 years and was taught how to analyse and interpret data in large trials to inform my medical management. When I became interested in education research, I became aware that the positivist paradigm would not be able to fully answer my research questions. In my Masters' dissertation (Harris, 2013), where I was looking at near-peer teaching of a communications course and then my EdD studies where I started to focus on medical student professionalism (Harris, 2015; Harris, 2017), my research questions were formed with statements such as 'how?' and in 'what ways?' This type of question could only be addressed with an interpretivist theoretical perspective, seeking to understand the lived experiences and personal constructs of my participants. How they defined reality in different situations became key, as I started to piece together an understanding of the social world of undergraduate medical education.

'It is through daily interactions between people in the course of social life that our versions of knowledge become fabricated' (Burr, 2015 p. 4)

The other key part to interpretivist research is the involvement of the researcher in the actual research process where 'researchers are the instruments of the research' (Cohen *et al.*, 2017 p. 289). Positivist research seeks to keep the researcher out by using double blind techniques and eliminating bias; although Pring (2015) says separation is never absolute and a researcher always impacts on research. In contrast, interpretivist research acknowledges and even champions the researcher's involvement and uses this to generate increasingly rich data and further inform the social world (Burr, 2015).

There has been a tendency for medical education research to utilise the positivist paradigm and research methods from medical research (Monrouxe & Rees, 2008). However, this then misses the rich, contextualised narratives and humanistic features that are part of any educational endeavour (Gill & Griffin, 2009). When carrying out research it is necessary to have epistemological integrity and select a paradigm that ensures there is an appropriate connection between the nature of the

research, the theoretical perspective, research questions, design and methods (Marshall & Rossman, 2006). I therefore turn at this point to my research questions which describe in more detail what I am trying to discover when doing this research.

Research questions

Research questions are aiming to provide specific statements regarding the intentions of the research and turn the original purpose of the research into concrete, data-driven objectives (Cohen, *et al.*, 2017; Maxwell, 2005). The questions need to be specific enough to be achievable and finite and yet not too closed that they limit understanding of a topic (*ibid.*). In qualitative studies, research questions are often developed iteratively as the research progresses (Light *et al.*, 1990). This has certainly been my experience as I refined the context and direction of my enquiry through my reading and collection of the data. Bearing in mind that 'research questions are the consequence and not the driver of the situation' (Cohen, *et al.*, 2017 p. 305), I developed the following research questions: -

- **Do medical students from a variety of cultural backgrounds have a different experience of professionalism as they progress through medical school?**
- **Do negative experiences related to cultural factors affect the professional identity formation of students at medical school?**
- **What do students draw on to manage these negative experiences as they develop a professional identity?**

Selection of a research paradigm

Looking at the overarching aims of this research project; I am attempting to uncover the effect of cultural experiences on professional identity formation of students and how they frame these experiences through their social interactions. I therefore need to select a paradigm that will give insights into the social world of my participants and try to understand the meanings they were forming from these social interactions.

Social constructionism is a type of interpretivism which suggests that people are actively trying to seek out their own world views through a process rooted in a socio-cultural context (Hammersley, 2013). Constructionist research recognises that researchers are aiming to interpret the social world of the participants (Preissle, 2006) and that the act of the participant relating their narrative is in itself generating meaning (Burr, 2015; Savin-Baden & Howell Major, 2013). Constructionism works on the basis of one or more of four assumptions, (i) the research is intended to critique accepted ways of understanding the world and ourselves, (ii) understandings are shaped by time and place, (iii) knowledge is constructed through social interaction particularly through language and (iv) different constructions of the world will elicit different behaviours (Rees *et al.*, 2020). Social constructionism therefore seemed the appropriate choice of paradigm for a study into medical students' views of professionalism where, as discussed above, the nature of medical professionalism can in itself be viewed as a social construct (Hafferty, 2016).

However, I have also at this point considered social constructivism as an additional paradigm. Although both are interpretivist paradigms, constructionism and constructivism have different underlying premises (Burr, 2015). Whereas constructionism focuses on interactions in the social world, constructivism which is derived from theories of Piaget and Vygotsky, is more concerned with individual agency (Talja *et al.*, 2005). In social constructivism the focus is on the individual using experiences from the social world and creating their own individual meaning (*ibid.*). This distinction is relevant for this study where the whole project is taking place in a social constructionist framework, but consideration of how the medical students manage their developing professional identities through impression management is taking place through a constructivist view. In both constructionism and constructivism, involvement of the researcher and the biases that they bring to the research can affect the outcome. There is a need to maintain reflexivity at all stages of the research and this is considered in the next section.

A need for reflexivity

It is important in the research process to recognise the involvement of the researcher and the influence of the social world through a process of reflexivity.

'Reflexivity suggests that researchers should consciously and deliberately acknowledge, interrogate and disclose their own selves in the research'
(Cohen *et al.*, 2017 p. 303).

I have considered two types of reflexivity as I have undergone this study. The first is my personal reflexivity which I have discussed above in the reflective statement and introduction. This involves my own 'positionality' or how I see myself and others which will be influenced by my cultural beliefs, including those related to the protected characteristics I am studying: gender, race and ethnicity and social class. This also relates to considerations about the 'power' I have over my research participants and how that may affect their narrative choice as well as the interpretation I make of their account (Burr, 2015). As mentioned above, Bourdieu was keen that researchers considered their personal reflexivity in any research project to increase the validity of the research (Bourdieu & Wacquant, 1992). The reflexivity applied to the findings in this research is an example of the rigour of the research and allows for a measure of validity (Guba & Lincoln, 2005).

The second type of reflexivity is something Willig (2013) refers to as 'epistemological reflexivity' and relates to assumptions about the world surrounding this research project. Nearly all educational research is rooted in social science practice that developed in Western universities (Preissle, 2006). Researchers and the methods they use are inevitably influenced by the politics and practices of the social world (King & Horrocks, 2010; Pring, 2015). To some extent this is a deliberate intention, since I am undertaking an educational doctorate designed to be studied in my own professional world. However, this means that the selection of topic and the way I am choosing to view this has already been pre-determined to some extent by the prevailing discourses. Neither I, as researcher nor the participants come to this

research without prior knowledge of the topic. Therefore, the WP agenda and the competency based educational requirements that frame this study, impact this research since exposure to these discourses is the lived experience of both the researcher and participants. This will both frame the responses of the participants, perhaps moderating their answers to certain social norms (King & Horrocks, 2010) and affect how I choose to interpret them. This speaks to Pring's (2015) view of false dualism, as my constructionist research project is inevitably affected by realist ontology. One way of ensuring reflexivity of a project is to consider the ethical impact of the research at all stages and I turn to ethical considerations in the next section.

Ethical considerations

Ethical research has a long tradition, under the Hippocratic Oath of 'first do no harm' or *primum non nocere*. I have experience of research integrity from medical practice in following the Universities UK Concordat Act (2019) 'ensuring that research is conducted according to appropriate ethical, legal and professional frameworks, obligations and standards'. However, this is mostly related to positivist research and moving into the social science field, there are additional ethical considerations. It is often thought that qualitative research requires a 'lighter' ethics process than quantitative research, however according to DiCicco-Bloom and Crabtree (2006), all interviewing is invasive and may have far reaching effects.

There are many approaches to ethical theory however as a social constructionist study, I have chosen to apply the theory of *ethics of care* (Zwozdiak – Myers, 2020). This theory suggests that attitudes and values are dialogically created within social relationships and researchers need to,

'seek out and listen carefully to voices embedded in their social context to gain a true understanding of what people are saying and why they do what they do' (Howe & Moses, 1999 p. 32).

By further considering the social context and political world, researchers can negotiate the potential conflict between a desire to discover and disseminate knowledge and a desire to protect the anonymity of the participants and institutions involved (Pring, 2015). I have therefore drawn on the British Sociological Association's Statement of Ethical Practice, which addresses in detail the nature of power relationships between researchers and participants as well as consent and anonymity (British Sociological Association, 2017). I consider these aspects in more detail below.

Power relationships – as a social constructionist research project, the aim was to co-construct the research together with the participants. However, I was keen to mitigate the explicit power relationships with my participants by selecting medical schools other than my own. This meant I was not known to the participants, and I had no effect on their progression through the school and so was able to avoid an issue often seen within a professional doctorate known as insider research (Robson, 2011). I introduced myself as a doctoral student at UCL and did not reveal my medical school role, although I told some participants that I was a GP. Although there was a clear age difference and I was probably still regarded as a senior medical figure, I believe the participants were able to be more honest than if I had interviewed students at my own school.

Consent – The returning of the questionnaire was deemed to imply consent and questionnaires were anonymised from the outset. However, if participants wanted to be contacted for an interview, they needed to put email address at the end of the questionnaire. Other students were recruited by a QR code on a flyer. When they made contact, they were sent an information sheet (Appendix 1) and a consent form (Appendix 2) to return before the interview. I checked again at the beginning of the interview if I could audio record and specifically asked if could quote their words in the dissertation while maintaining anonymity.

Anonymity: Questionnaires were anonymised from the outset and each interview participant was given a code number before data was sent to the transcriber.

However, it is often not sufficient to simply remove the name from data. Sometimes it is possible to identify the participants from other information they have given in the interview (King & Horrocks, 2010). I told the participants explicitly that they would remain anonymous and not be identified by other means. For example, one participant told me that they were from a small Caribbean country and their medical school year so they could potentially be identified. This information was therefore redacted.

Potential adverse outcomes generated by interview: When dealing with sensitive topics in an interview format, there is potential for participant to reveal something that could increase their moral distress (Richards & Schwartz, 2002). I was concerned about this since my participants were revealing incidences of discrimination in their workplace which they may have found upsetting. There was also a possibility of students revealing events that I would recognise as poor professionalism and that may lead to a patient safety concern. As the researcher, I could not address this as I normally would in my medical school role although as a GMC registered medical practitioner, I am also bound by the Duty of Candour (GMC, 2015). If such an event had been reported, I would have encouraged the student to report this through the appropriate channels or seek additional permission to break confidentiality. In the event, the participants did not appear distressed by the process and no patient safety concerns were raised.

Having considered the above issues, this study obtained a data approval reference number Z6364106/2019/01/80 for social research in line with UCL's Data Protection Policy which included compliance with GDPR guidelines and was then reviewed and approved by the IOE, UCL research ethics process.

Research Design

Having considered the philosophical principles, and ethical considerations that impact this research, this section now considers aspects of the research design. I discuss sampling, data collection tools, data management and data analysis and

show how each of these were selected with a view to the underlying methodological approach and as a means to answer the research questions. A table linking the methodology to methods is shown below in Table 3.

Table 3: The linking of methodology to methods

Ontology	Epistemology	Theory	Data collection tools	Analytic approach
Interpretivism	Social constructionism/ Social constructivism	Bourdieu (habitus capital and field) Goffman (symbolic interactionism)	Questionnaires Interviews	Thematic analysis

Sampling methods

Selection of medical schools

There are currently 44 schools in the UK that accept students onto a medical degree course, with the vast majority of students in this country entering medical school as school leavers (MSC, 2019b). Entry requirements vary between schools, but most require high grades at A level or the International Baccalaureate, plus success at a separate entrance test and an interview. Competition for places at medical school is high with more than 30,000 applicants competing for 9,500 places in 2019 (MSC, 2021).

There is a certain uniformity in the teaching that occurs at medical school in the UK derived from the GMC guidelines *Tomorrow's Doctors* (GMC, 1993) and more

recently *Outcomes for Graduates* (GMC, 2018a). The MSC Assessment Alliance has developed a national set of common content questions that comprise 10% of written finals examinations. From the academic year 2024/2025, all students will need to pass a national Medical Licensing Assessment (MLA) comprising a selected response paper and practical examination, to gain a licence to practice from the GMC (GMC, 2017). In addition, there are currently other national assessments (Prescribing Safety Assessment, Situational Judgement Test) contributing to final year assessments. This move to a national graduating standard has come from the discourse of standardisation with an expectation that UK medical schools are teaching a common curriculum and adopting a uniform culture.

However, as already discussed, medical schools are often considered places of occupational socialisation and due to the hidden curriculum, the culture of one institution can have an undue influence on the expression of professional values at that school (Hafferty, 2016; Wear & Kuczewski, 2004). In this thesis, I chose to interview students at what I believed were two contrasting medical schools, named in this study as Acorn and Beech medical schools. I had originally wanted to include a third school in my research design but permission to collect data at that school was subsequently withdrawn. My reason for using two schools was not to directly compare the schools as I thought I would not collect enough data to make this valid, but to broaden the scope of the study. I hoped that by collecting data from two contrasting schools, I may be able to collect a wider range of data. I was also keen to avoid the recent critique of medical education research that it was narrow in its scope and often taking place at a single institution (Brosnan & Turner, 2009).

Other empirical research into professionalism often presents data from one institution and it is therefore difficult to make assumptions about the generalisability of the results (Broad *et al.*, 2018, Lempp, 2019). Although qualitative research is usually not generalisable, increasing the number of settings where the research is carried out increases the external validity of the research often through the measure of 'comparability' and 'transferability' (Cohen *et al.*, 2017; Lincoln & Guba, 1985). I involved two contrasting medical schools to broaden the impact of the data and allow

the conclusions to carry more weight in my professional practice. The published socio-demographic characteristics of the selected medical schools are listed in Table 4 below.

Table 4: Comparing Acorn and Beech medical schools (with data from GMC, 2018b; The Medic Portal, 2021; Office of National Statistics, 2011)

	Acorn	Beech
Location	Small urban (town or city <500,000 inhabitants)	Large urban (town or city >500,000 inhabitants)
Index of multiple deprivation (IMD) decile	4	7
Years since opening	~25	>150
Russell Group?	No	Yes
Number of students per year	Approx. 150	Approx. 350
Foundation course	Yes	No
Intercalated BSc	Optional	Compulsory
Course structure	PBL	Integrated
Minimum entry requirements	AAB	A*AA
Entrance test	UKCAT	BMAT
Ethnicity data from Medical Student Annual Return (MSAR) 2017/18 (GMC, 2018b)	n=478	n=1961
White	60%	44%
Black	17%	23%
Asian	12%	20%
Mixed	4%	7%
Other	7%	6%

Although the Medical Schools Council publishes national data on WP and protected characteristics (MSC, 2019a), it has as yet resisted calls to publish individual school-based data (Apampa, 2019). The ethnicity data has therefore been derived from the GMC Medical Schools Annual Return (MSAR) data sent annually by each medical school to the GMC (GMC, 2018b).

Acorn is a newer medical school, being established only 20 years ago and is not part of a Russell Group institution. It has a standard 5-year medical programme, with an optional intercalated BSc and a small intake each year. The minimum entry requirements are amongst the lowest published for medical degrees and there is a foundation course to assist students who do not have the appropriate qualifications gain entrance to medical school.

Beech is a long-established medical school and is part of a Russell group university. It has a 6-year medical programme with a compulsory intercalated BSc and a large number of students per year. The minimum entry requirements are higher than Acorn school with no foundation course.

From the description of these two schools, it is possible that Acorn and Beech school may admit students with a differing socio-economic status. For example, foundation courses, present in the Acorn programme have been shown to demonstrate an active commitment to WP and greater socio-economic diversity at medical school (Garlick & Brown, 2008; Apampa *et al.*, 2019).

Selection of students and gatekeeper issues

Having chosen the school, I then needed to select which students I would sample for both the questionnaire and interviews. Although not having a role in the school improved the power dynamics between myself and the participants, it introduced some *gatekeeper* issues with accessing participants. King and Horrocks (2010) defines a gatekeeper as 'someone who has the authority to grant or deny permission to access potential participants and or the ability to facilitate such access' (King &

Horrocks, 2010 p. 31). Robson (2011) discuss gatekeepers as stakeholders who may restrict access to participants through 'overprotectiveness' (Robson, 2011).

Due to volumes of research approaches, most educational institutions now have a policy to not allow mass emailing of students, so I needed to find another method to access the participants. At both medical schools I utilised an 'insider' assistant to help with recruitment and gain the necessary access as recommended by King and Horrocks (2010). Morrison (2006) also stresses the benefits of using existing connections, however it is important to ensure that they are well briefed on the purposes of the research yet remain independent of the outcomes (Cohen *et al.*, 2017).

The questionnaire was written on the commercial survey platform, Survey Monkey™ and accessed by a QR code on a flyer. The intention was that the questionnaire would generate students interested in the cultural aspects of professionalism who would then subsequently put themselves forward for a telephone interview. Due to COVID-19, the time lapse between collecting the questionnaire data and carrying out the interviews meant only one student who completed the questionnaire was available for interview. I therefore needed to use different strategies to recruit additional participants for the interview opportunity. Uptake was initially slow, but I was subsequently approached by sufficient numbers of students from both schools to allow for *purposive sampling*.

Purposive sampling is used in qualitative research to ensure a broad range of participants who are best placed to answer the research questions (Bryman, 2012; Silverman, 2000). Since I was only able to hold semi-structured interviews with a limited number of participants, I wanted to try and ensure that I was sampling across a range of students in terms of their protected characteristics and that all students interviewed would be able to contribute to answering the research questions (DiCicco-Bloom & Crabtree, 2006). It has been reported than men are more likely than women, and white participants more likely than BME individuals to volunteer for educational research leading to a possibility of *volunteer bias* (Callahan *et al.*, 2007).

In fact, I had more women offering to be interviewed and also a large number of students from the early years. I discovered after a few interviews that the students who had had clinical exposure in years three to six were able to talk about a broader range of experiences and I targeted my later interviews at these clinical students. This fits within the paradigm of social constructionism and becomes a type of *theoretical sampling* (Robson, 2011). Having considered the selection of schools and participants I now continue to discuss the choice of data collection tools.

Data collection tools

I considered the interpretivist nature of this study and selected data collection methods aligned to a qualitative methodology; namely a questionnaire and interviews. In the questionnaire I included Likert scale and free text questions which gave both numerical and textual elements to the data and then combined this with the qualitative data from the interviews. The use of numerical data could be considered a quantitative method, meaning that together with the interviews this could be termed a mixed methods study. Mixed methods studies are broadly defined by the literature as any research where both qualitative and quantitative data are collected (Anguera *et al.*, 2018; Cresswell & Plano Clark, 2011). Since this study is carried out in a constructionist paradigm, this is better described as *multimethods* research which allows for the collection of different types of data in the same paradigm (Anguera *et al.*, 2018). This can be termed an *explanatory sequential design* with the numerical data providing descriptive statistics to inform the textual data (Cresswell, 2014).

Questionnaire

This study used a questionnaire written on Survey Monkey to broadly sample opinion in the two medical schools and also act as a selection tool for the interviews. I chose to survey large numbers of students at each school to get a sense of the prevailing issues surrounding culture and professionalism. My first research question asks, 'Do medical students from a variety of cultural backgrounds have a different experience

of professionalism as they progress through medical school?’ and I thought I may not be able to sample sufficiently widely by only performing interviews.

The aim of a questionnaire is to produce a set of items that will be interpreted in a similar way by all participants, so they will be motivated to deliver meaningful responses (Artino *et al.*, 2014). As I developed the questionnaire, it was important to plan with the research questions and data analysis in mind, carefully considering the constructs I was aiming to explore (Artino *et al.*, 2014; Cohen *et al.*, 2017). I spent some time writing and rewriting the questionnaire in Survey Monkey, trying to avoid leading questions and including a format that would encourage participant completion (Dillman *et al.*, 2009). I was particularly aware that asking questions about culture and class had a potential to cause offence (Cohen *et al.*, 2017). The questionnaire consisted of five Likert scale and four free text questions and allowed participants the option to leave certain questions blank (Dillman *et al.*, 2009). I performed an *expert validation review* by asking my supervisors to critique the questionnaire and I first piloted the questionnaire with some other students to get their views about any possible ambiguity of the questions (Artino *et al.*, 2014).

Interviews

I chose to gather in-depth data from my participants in the form of interviews. This fits well with the social constructionist paradigm as the dialogue with the participants allows for a co-construction of the narrative (Burr, 2015; Kvale, 2009). As the participants recounted their stories they were also forming and re-framing their own views of the subject matter (*ibid.*). The act of telling the story often cannot be separated from the event itself and individuals are forming versions of their identity by describing themselves to others (Holland *et al.*, 1998). However, there are also critiques to using interview data to derive knowledge, as some feel that participants may be more focused on self-presentation and the impression they are giving rather than offering their true opinions (Hammersley, 2003; Murphy *et al.*, 1998). Hoskins (2020) asks how the researcher can know whether they are hearing a presentation of the information, or the information itself. However, this can be mitigated by being reflexive and considering the context of the interviews (*ibid.*). This concern is less

relevant in this study as I am considering symbolic interactionism as one of my theoretical concepts as discussed above. I am interested in how the participants are using constructivism and impression management to construct aspects of their developing professional identity. Therefore, the interviews can be seen as a meta-analysis, looking at how the participants are choosing to describe their experiences as much as the recounting of the experience itself.

I decided that individual rather than group interviews were the most likely platform to enable the participants to be open about sensitive issues and to have enough private space to explore meaningful perspectives (Savin-Baden & Howell Major, 2013). Interviews exist on a spectrum from fully open interviews to strictly scripted structured interviews (DiCicco-Bloom & Crabtree, 2006). I chose to use semi-structured interviews, as this utilised a topic guide and a basis for asking the same questions to all participants but allowed for an iterative process so I could introduce new questions into subsequent interviews and explore interesting points raised by the participants (King & Horrocks, 2010; Kvale, 2009). This approach between a normal conversation and a questionnaire fitted with the constructionist paradigm and enabled me to collect high quality rich data with the participants relating their own world views (Kvale, 2009; Miles *et al.*, 2013).

Due to the distance to the two participant schools and then the advent of the COVID-19 pandemic, I had to carry out all interviews by telephone. My previous interview experience has been face-to-face (Harris, 2013; 2015; 2017) and I needed to consider the impact telephone interviews would have on my research. Telephone interviews differ in style to face-to-face interviews as a lack of visual cues tends to make them more task-focused and transactional (King & Horrocks, 2010; Shuy, 2002). However, Kee and Browning (2013) argue that there are several advantages to telephone interviewing, including a tendency to neutralise power differentials and increase the disclosure by the participants when discussing sensitive data. For this reason, I decided not to

interview via a video platform such as Zoom™ or Microsoft Teams™. It is possible for the interviewer to mitigate some of the negative aspects of telephone interviews by being clear at the outset about the purpose and duration of the interview (Lechuga, 2012).

Choice of a tool to measure social class

As mentioned in chapter 3, it is not easy to define socio-economic class in students as it is often classified on occupation, and students are not part of the current workforce (ONS, 2010). Designation of an individual's social class has been controversial in the past with economists wanting to base this on household income and sociologists on occupation and attached status. (Friedman & Laurison, 2019). Recently there has been a move from sociologists to avoid occupational group classifications and base definitions of class on access to resources and social capital (Robb *et al.*, 2007). However most sociological research in the UK uses one of two main classification tools: the Standard Occupational Classification (SOC) or the National Statistics Socio-economic classification (NS-SEC).

The most commonly used tool is the **Standard Occupational Classification (SOC)** used by the Office for National Statistics (ONS) and updated every 10 years with information derived from the census (ONS, 2020). Since 2014 this has included the social mobility question 'when you were 14 what was the occupation of the main income-earner in your household' (Friedman & Laurison, 2019). This question is particularly useful when considering the social class of students and is one that I used in this study. The major groups of SOC20 are listed below: -

1. Managers, directors and senior officials
2. Professional occupations
3. Associate professional occupations
4. Administrative and secretarial occupations
5. Skilled trade occupations
6. Caring leisure and other service occupations

7. Sales and customer service occupations
8. Process plant and machine operatives
9. Elementary occupations

The **National Statistics Socio-Economic Classification (NS-SEC)** was developed in 1994 following criticisms that SOC did not include the individual's status within each occupation (ONS, 2010; Rose & Pevalin, 2003). The NS-SEC is now widely used by government departments and academic research as a measure of social class as it describes employment relations (such as employed or self-employed) and conditions of employment rather than just the title of the occupation (ONS, 2010) It is also used by the Medical Schools Council to describe the social class at entry into medical school.

This study used the SOC20 categories in the questionnaire to capture the initial data and some modifications were made to bring this into line with NS-SEC data used by the MSC. A quantitative measurement of social class may not be well aligned with a constructionist study using Bourdieusian principles, however it can be argued that as a self-reported tool it gives a baseline understanding of socio-economic status which can be used to further explore the habitus of an individual (Burke, 2016).

Participants were asked to name the occupation of the highest earning parent when they were 14 and this data was applied to the NS-SEC categories using ONS published conversion tables in order to allow a direct comparison with government and Medical School Council data (ONS, 2020). In line with the Medical Schools Council, I simplified the data into three main categories, with 1 and 2 termed the higher managerial and professional occupations, 3 and 4 the intermediate occupations and 5 to 8 the lower or routine and manual occupations and these categories are shown in the Table 5 below.

Table 5: NS-SEC social class classification; eight and three class versions

	Derived NS-SEC classification	Broad class
1	Higher managerial, administrative, and professional occupations	Higher Occupations
2	Lower managerial, administrative, and professional occupations	
3	Intermediate occupations	Intermediate Occupations
4	Small employers and own account workers	
5	Lower supervisory and technical occupations	Lower Occupations
6	Semi-routine occupations	
7	Routine occupations	
8	Never worked /long term unemployed	

Data management

The questionnaire data was collected in Survey Monkey between 28th September 2019 and 13th July 2020. The data was analysed on my personal password-protected computer using Survey Monkey tools and Microsoft Excel™ spreadsheets. Qualitative data was obtained from the four questions in the questionnaire that required free-text responses and were answered by between 68 and 83% of participants. All the questionnaire data was anonymous at the point of collection although some students had added an email address if they were willing to be

contacted for interview. Questionnaire participants were given the code number S1-S79 with the suffix Acorn or Beech depending on medical school.

In addition, I carried out 12 semi-structured interviews by telephone with six participants at each medical school between the dates 6th March 2020 and 16th February 2021. The interviews were audio recorded either on my mobile telephone or a hand-held recording device and were uploaded to my password-protected computer. At this point, each of the interview participants was given a code name e.g. A1, B2 according to the medical school they attended (Acorn or Beech) and the order they were interviewed. The recordings were then deleted from the original recording device.

I have previously transcribed my own participant research interviews (Harris, 2013; 2015; 2017) and this has a benefit of allowing the researcher to fully immerse themselves in the data (Braun & Clarke 2006). However, being realistic about the time commitment required for doctoral study made me select a professional transcription service (Gill *et al.*, 2009; Kvale, 2009). The act of transcribing audio data is often mentioned only briefly in research methodology yet needs careful consideration as the choices made around transcription should be linked to the underlying research paradigm and have implications on the type of data collected (Davidson, 2009; Kvale, 2009; McMullin, 2021). These interviews were transcribed by a professional transcriber using *naturalised* or *intelligent* transcription. This gave a verbatim account but repetitions, 'ums' and 'likes' were not transcribed, so linking the transcription more closely to a written form of words (Bucholtz, 2000). This has the advantage of being easier to read and compare participants' data but is still relevant for use in a social constructionist study (Davidson, 2009).

I am aware that the transcriptions are themselves are a construction and represent a version of the truth (Davidson, 2009). To ensure the transcription was as close as possible to the participants' words, I checked the written documents carefully against the recordings for accuracy and made some minor changes although taking care not to alter the meaning with my own views (King & Horrocks, 2010). Some inaudible

words were added, and a few errors were corrected due to lack of medical knowledge such as 'placement' and 'firm'.

Due to the volume of data, the transcriptions were then uploaded into NVivo 12.6™ (QSR International Pty Ltd, Doncaster, Vic, Australia) for further data handling. I have previously analysed data by hand but found this software useful to manage the processing of data from two sources; the questionnaires and interviews. The consideration of codes and themes remained self-generated, but this software allowed an iterative process of assigning and re-assigning codes and a visual mapping exercise of the initial codes. This is an important point as it is the role of researcher to find meanings from within the data and not claim as many do that the themes 'emerged from the data' (Braun & Clarke, 2021; Connelly & Peltzer, 2016).

I was keen to integrate the data both between the qualitative and quantitative data and the two sources of free text data from the questionnaires and interviews. This would allow for one complete data set from which to generate codes and themes. This process of amalgamation of data sets differs from a triangulation protocol, which is often concerned with confirming the accuracy of the research findings (Bryman & Burgess, 1994; O'Cathain *et al.*, 2010). Triangulation of this nature would not have an epistemological fit with this social constructionist study. Instead, I wanted to ensure that all the data contributed equally to answering the research questions and chose to use a *following the thread approach* (Moran-Ellis *et al.*, 2006). With this integration method, I picked a theme in one dataset and based on the original research questions followed it across the other data sets to create a multi-faceted picture of the phenomenon (*ibid.*).

Data analysis

Due to COVID-19, I began to analyse the data from the questionnaire before commencing the interviews and started to analyse the interviews before they were all complete. This fits with a constructionist approach which suggests that informal analysis should commence as soon as the first pieces of data are collected

(Crawley, 2020). Early data analysis allowed an initial understanding about the research questions and suggested other areas of exploration (DiCicco-Bloom & Crabtree, 2006). For example, analysis of the questionnaire revealed that gender issues were more significant to the participants than previously thought and led to altered interview questions. I was also able to add questions to later interviews about the participants' readiness to be a doctor, generated by comments made in earlier interviews.

When analysing the data, I decided to undertake all the coding myself as this fits the constructionist approach of the researcher being fully immersed in the data and generating a version of the truth. Braun and Clarke (2013) feel that the use of multiple coding imports quantitative methods into an interpretivist study and this has no place in a *reflexive thematic analysis*. In addition, the regulations for the doctorate state that the thesis must be my own work (EdD handbook 2022-23). However, I am aware that by generating all the codes myself, I have described the truth through my personal lens that may reduce the external validity and generalisability of the findings. One way to mitigate this has been the reflexivity used throughout and discussed in more detail in the reflexivity section above (p.88).

Thematic analysis

Although as discussed above, I was using the lenses of Bourdieu and Goffman and specifically a Bourdieusian three-stage analysis to analyse the data, I also needed a tool to further analyse the free text comments. I chose thematic analysis (TA) as best suited for this constructionist study as it is flexible and can be adapted to use with other social theories. Thematic analysis was first described by Braun and Clarke in 2006 as a qualitative analytic method to use alongside more positivist research methods in psychology (Braun & Clarke, 2006). There have been many variations of this analysis method with more positivist research using a framework of deductive coding to predefine the codes before analysing the data (Braun & Clarke, 2021). It has also been recommended as a useful method for analysis of health outcomes

(Braun & Clarke, 2014). However, the authors have defined a subset of thematic analysis that they call *reflexive thematic analysis* (RTA) which,

'emphasises the importance of the researcher's subjectivity as analytic resource and their reflexive engagement with theory, data and interpretation'
(Braun & Clarke, 2021 p. 330).

This reflexive thematic analysis is particularly suitable for a social constructionist project and allows for inductive coding, although taking note that every study is subject to existing research and theory and provides a lens through which we analyse data (*ibid.*).

Braun and Clarke (2021) provide a six-phase process for data engagement (while also stating that any written pro-forma can be misinterpreted as prescriptive). The stages are: -

1. Data familiarisation and writing familiarisation notes
2. Systematic data coding
3. Generating initial themes from coded and collated data
4. Developing and reviewing themes
5. Refining defining and naming themes
6. Writing the report

The first stage of data analysis in a qualitative study is always immersion in the data (Braun & Clarke, 2006; Green *et al.*, 2007). I read through the free text comments from the questionnaires and checked all the transcripts against the recorded interviews and read these once more. Then without any preconceived ideas, I assigned codes to statements made by the participants in both the questionnaire and interview data. This was an iterative process as I coded more transcripts I found certain codes, for example 'negative comments' were amended to include 'comments from patients' and 'comments from colleagues'.

Green and colleagues (2007) suggest inserting *categories* as an additional step between that of code and theme, and I found this useful in the above example to categorise these as racist, sexist or classist comments and then develop these further into a theme. The steps taken are shown in Table 6 below.

Table 6: An example of steps taken in RTA to code data into themes

Step 1	Step 2	Step 3	Step 4
Data immersion	Coding	Creating categories	Identifying themes
Read and re-read data transcripts	e.g., negative comments from patients	Racist comments	Dealing with racism in the workplace
	e.g., negative comments from colleagues		

The pitfalls in coding relate to confusing codes and categories with themes and can lead to an *analytical foreclosure* (Connelly & Peltzer, 2016). This can happen where codes or categories are reported as the data findings, often with numerical descriptors to explain differences in the data such as ‘some’ participants stating a certain view (Green *et al.*, 2006). Premature closure may also occur if the interviewing has not been in sufficient depth to obtain detailed descriptions of the participants’ experiences (Connelly & Peltzer, 2016). It is important to consider the categories in light of the research questions to generate underlying themes and an RTA ensures there is a constant consideration of the researcher’s personal views and biases. An example of the initial codes and themes generated together with a visual map of how these may connect can be seen in Appendices 3 and 4. Thematic analysis does not itself sit within a theory but can be linked with other theories and in the next section I show how Bourdieu’s concepts can be applied to a thematic analysis.

Application of thematic analysis to the theories of Bourdieu and Goffman

In addition to the thematic analysis discussed above, I am also using theoretical perspectives discussed in Chapter 2, Bourdieu's theoretical framework of *habitus*, *capital and field* and Goffman's theory of *impression management*. Bourdieu who was keen to operationalise his theory, presented a possible three-stage field analysis for researchers as set out below (Bourdieu & Wacquant, 1989; 1992; Grenfell, 2012b).

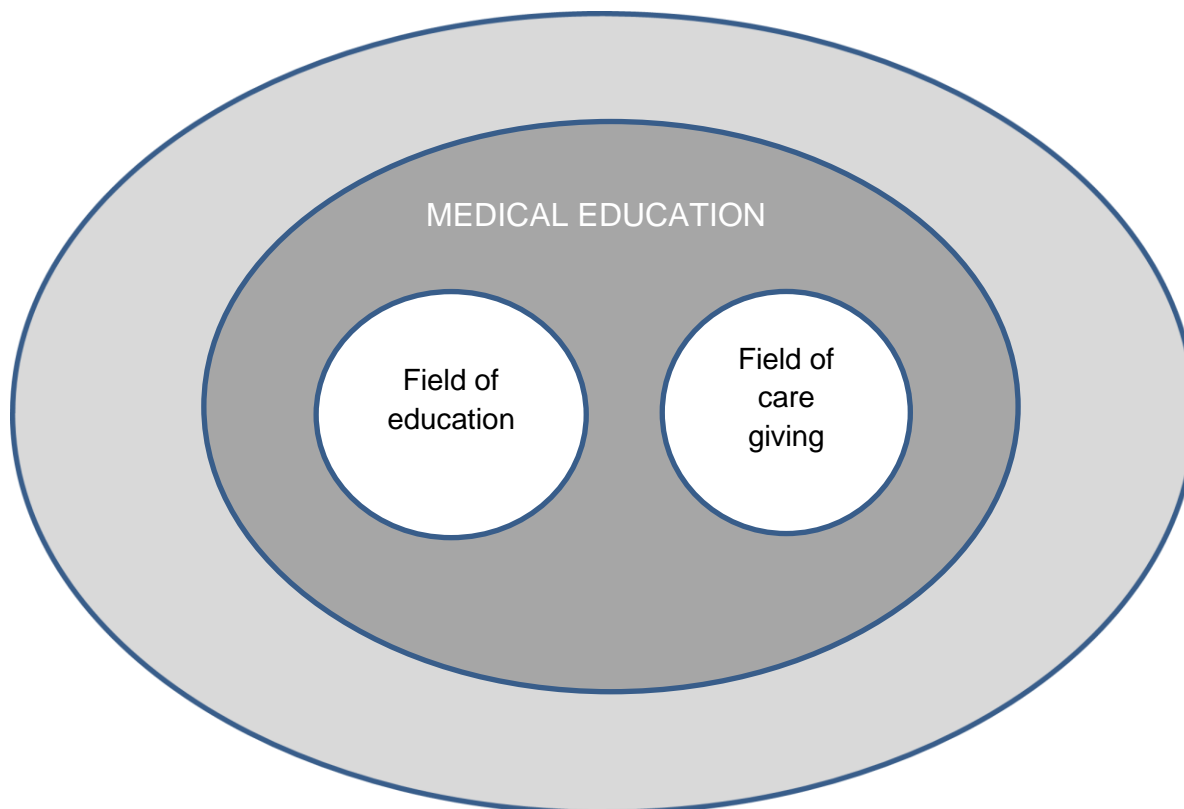
Bourdieuian field analysis

- (i) Analyse the position of the *field* in relation to the field of power (politics, government)
- (ii) Map out the objective structure of the position of the agents in the field and the *capital* they are utilising
- (iii) Analyse the individual agent and their *habitus*

When analysing the position of the field I have noted this may contain several subfields with participants being members of more than one field (Grenfell, 2012a). For example, in this project I have chosen to define the fields and subfields of medical education as in Figure 3 below: -

Fig. 3: Representation of sub-fields within medicine (based on Bourdieu & Wacquant, 1992).

MEDICINE



Medical education in common with other vocational subjects takes place in two settings broadly divided into areas of knowledge acquisition and skills acquisition. In medicine, I have chosen to term these the *field of education* and the *field of care giving*. Although students move between each field during their course, the field of education mostly represents medical school based teaching and the field of care giving mostly represents teaching in the clinical placements. The participants have differing amounts and types of capital in each field and use these to reinforce their habitus and cement their positions in each field.

Bourdieu & Wacquant (1992) suggest that the first step is to analyse the position of the fields relative to the field of power. I cover the analysis of medicine and medical education and the political and power influences in the literature review chapters

above. In the data analysis chapter, I use the other two stages of the three-stage analysis. I initially describe the individual habitus of the participants in this study looking at the demographic data, social class and ethnicity. I then use reflexive thematic analysis to analyse and code the experiences of the students and show how depending on their original habitus they either use these experiences as capital to cement their position in the field, or experience dissonance as these threaten their habitus. I go on to explore the relationships between the participant's habitus and the dispositions they have acquired from these experiences and discuss how this affects their professional identity, particularly drawing on aspects of the hidden curriculum. I show how the hidden curriculum allows us to perpetuate the doxa in the field and how the students use social constructivism in the form of impression management (Goffman, 1959) to manage the threats to their habitus. By using the above framework, I am able to apply the reflexive thematic analysis to the Bourdieusian concepts of habitus, capital and field and Goffman's theory of impression management.

Reflections on methodology

This chapter has set out the chosen methodology and methods for this study and my reasons behind these choices. Some of these choices were influenced by pragmatic reasons that have probably affected the type and nature of data collection. Students are often over-surveyed and trying to ensure the questionnaire was answered by a broad range of students in two schools was challenging. This was exacerbated by the COVID-19 pandemic that started during my data collection as I was not able to visit schools to encourage participation. Although I achieved a good number of questionnaire participants (n=79) these are mostly from the early years in Acorn school, and this may mean the sampling was not fully effective. Similarly trying to get enough students to agree to be interviewed was challenging and took several iterations of displaying a leaflet with a QR code.

In the interests of time, I chose professional transcription of the interviews, and this added an additional layer between myself and the data which may have delayed my

immersion in the data (Kvale, 2009). Conversely, I generated my own codes for the RTA since this is required for a professional doctorate, but guidance on this method usually suggests more than one coder with discussion to generate final codes (Braun & Clarke, 2021). As a constructionist study and in retrospect, I would have liked the option to approach the students again for a short follow up interview as there were some additional questions that could have been asked after further analysis of the data relating to their impression management. However, on balance I feel the approach used on this study has allowed me to sufficiently explore this issue and provide answers to my research questions.

Summary

This chapter has explored the philosophical underpinnings of this work and described how the research questions have informed the methodology and methods used in this study. It shows how the world is defined by the competing paradigms, but this may be a false dualism with more overlap between the paradigms than generally thought. This is significant in this study where I am using existing social theories to attempt to combine the paradigms. The methods and use of RTA as a data analysis tool are described in detail and I show how the Bourdieusian concepts of habitus, capital and field are incorporated in the thematic analysis. In the next chapter, I present the demographic data together with the outputs of the thematic analysis from the questionnaires and interviews and show how Goffman's theory of impression management can be used to understand how the students manage their emerging professional identities.

Chapter 5: Data and Analysis

Introduction

This chapter summarises the output of the data collection related to the research questions and the theoretical constructs outlined above. This study has provided data from two main sources: data from a questionnaire (n=79) distributed in two medical schools, and data from 12 interviews from the same medical schools which generated 238 minutes of audio data.

Only one student both completed a questionnaire and was subsequently interviewed and so the participants largely represent different populations of medical students. As mentioned above, I have used a *following the thread approach* (Moran-Ellis *et al.*, 2006) to ensure that data from both the questionnaires and interviews were considered synoptically as one dataset. This approach allows for a full integration of the data from more than one source whilst retaining the epistemological integrity of a social constructionist study.

I am studying the cultural aspects of professional identity formation as students move through education and into a professional role. I have chosen to analyse the data through the lens of the social theories of Bourdieu and Goffman. Bourdieu's concept of exploring the habitus of an individual and how it is influenced by capital in the social field is a useful way to frame this data. Goffman's performance management theories provides a more agentic theory to help to explain the strategy of students as they manage negative experiences. These theories are a way of bridging the paradigms that underlie concepts of professional identity formation to provide a cohesive overview.

Bourdieu was always keen to operationalise his theories and apply them to empirical data (Grenfell, 2012b). I am therefore following the three-stage model of a Bourdieusian field analysis as set out below (Bourdieu & Wacquant, 1992) and applying this to the full data set. However, I needed to select another tool to further generate codes from the data and since this is a constructionist study, I have

selected the method of a reflexive thematic analysis to generate codes for the free text comments and interview data (Braun & Clarke, 2021).

Bourdiesian field analysis

- (i) Analyse the position of the *field* in relation to the field of power (politics, government)
- (ii) Map out the objective structure of the position of the agents in the field and the *capital* they are utilising
- (iii) Analyse the individual agent and their *habitus*

Analyse the position of the field in relation to the field of power.

In the first stage of the Bourdieusian field analysis, I consider the position of the field in relation to the field of power. In chapters 2 and 3, I have discussed the discourses and hierarchies present in the field of medical education and how these relate to the field of power. The sources of power are in flux and subject to the competing discourses present in medicine, with conflict between the discourse of diversity and standardisation causing confusion and tension (Frost & Regehr, 2013).

I have found it useful when analysing the data to divide the social field of medical education into subfields of *field of education*, mostly representing the early years at medical school and *field of care giving*, mostly from the later clinical years as there appeared to be some difference in the student experience (see Figure 3, page 109). Most medical schools have integration between the clinical and science teaching; however, for the purposes of this research, I am choosing to present these subfields as discrete social rather than physical entities. Students in early years are sometimes describing their experience on clinical placement in the field of care giving and students in later years are sometimes referring back to their experiences in the field of education. In reality, students are moving back and forth between these two subfields utilising different forms of capital in each field, and I have considered this in the data analysis.

Overall, 71% of students in the study were in years 1-2 and therefore more likely to relate experiences from the field of education. However, this varied between the questionnaire, where 81% of participants were in years 1-2 and the interviews where 75% of participants were in years 3-6. This meant interview participants were more likely to relate experiences from the field of care giving. In the next step of this Bourdieusian analysis, I analyse the individual agents and their habitus.

Analysis of individual agent and their habitus.

Bourdieu named this as the third aspect of his field analysis, since he was keen for researchers to keep a broad outlook and remain reflexive before narrowing down into aspects of individual participants (Bourdieu & Wacquant, 1992). However, my study design of a questionnaire followed by interviews lends itself to considering specific aspects of the habitus of participants that may further inform the use of capital in the field. It is also relevant that most qualitative research using a Bourdieusian framework considers this data at the outset (Grenfell, 2012b). However, it is important to note although considering individual aspects of the participants in the form of demographic data, I am only reporting data that affects an individual's relationship with the field (Grenfell, 2012b). As this study uses purposive sampling with small numbers of participants, an additional aim in describing this individual data is to ascertain whether the proportions are comparable to large-scale national data sets (Cohen *et al.*, 2017).

The questionnaire was completed by 79 medical students; 60 (74%) from the newer school called **Acorn** in this study and 19 (23%) from the more well-established larger school called **Beech**. In addition, I interviewed six students from each school giving an overall total of 91 participants. The majority of students were in years 1-2 (71%) with 29% being in years 3-6 or the more clinically based years. All students were aged between 18 and 25. The gender reporting showed 62% of the participants were female and 37% male, with 1% preferring not to say. This is broadly comparable with the current intake to UK medical schools with the most recent Medical Schools

Council Selection Alliance report stating that 59.7% of students entering standard medical courses in the UK in 2017 were female (MSC, 2019).

The social class data is also broadly in line with the national intake to medical school. Only 77 students responded to this question, which together with the 12 interview participants meant that social class was considered for 89 students overall. Sixty-one students (68%) were in the top two managerial and professional higher categories with fourteen students (16%) in both the intermediate and lower occupation categories of NS-SEC (see Table 4, page 95). This is in line with the NS-SEC classification data quoted by *Selecting for Excellence* (2019), particularly in terms of the upper two classes. Out of the 5890 students entering medical school in 2017 (the last year for which data is available), 4100 or (69.6%) were from NS-SEC 1-2 with 1195 or 20.3% from the intermediate classes and 595 or 10.1% from the three lowest categories (MSC, 2019b).

This study also permitted an exploration of heritability by asking specifically about the parents' occupation when the student was aged 14. Data from the ONS Labour Force survey quoted in Friedman and Laurison (2019) shows that children whose parents are doctors in the UK are 24 times more likely to enter medicine than children with parents in other professions. The data from this study is broadly similar, with nine out of the 77 students in the questionnaire and two out of the 12 students interviewed saying the main wage earning parent was a doctor giving a total of 12.4% of all participants with a doctor parent. In addition, seven students (7.9%) said that the main wage earner followed an Allied Health profession such as nursing or midwifery and a further four (4.5%) students stated their main wage-earning parent had a caring occupation such as a 'carer'. This shows that nearly a quarter of all participants had a main wage-earning parent in some sort of caring profession. This compares to other classic professions such as law and accountancy which was stated as a parental occupation for between five and seven per cent of participants. This heritability data is shown in Table 7 below.

Table 7: Numbers in each medical school with the parental main wage earner in a caring profession or other classic profession (all participants).

Profession	Acorn	Beech	Total (n=77 + 12)
Doctor	5	6	11 (12.4%)
Allied Health e.g., nursing, midwifery	6	1	7 (7.9%)
Caring profession e.g., carer	2	2	4 (4.5%)
TOTAL	13	9	22 (24.7%)
Other classic professions			
Law	2	3	5 (5.6%)
Accountancy	3	3	6 (6.7%)

The unequal numbers of students responding from each school meant that I was not able to make meaningful comparisons between the data from Acorn and Beech schools. The two contrasting schools were included, not to provide a direct correlation but to broaden the scope of the study and enhance the applicability of the data (Cohen *et al.*, 2017).

Ethnic composition of the students from each school was obtained from national data sets, as this was not specifically asked in the questionnaire. The GMC produces national data on the ethnic composition of medical schools, and I have used this to estimate the ethnicity present at each school at the time of this study (GMC, 2018b). In 2017/18, Acorn medical school had a greater proportion of white students at 60%

compared with 44% at Beech medical school. This may be expected when comparing a medical school outside London to a London school. Of the 12 students interviewed, three gave their ethnicity as White British and nine stated an ethnicity from a non-white background. These ethnicities are listed in the detailed demographic data of the interview participants in Appendix 5, page 217. The demographic data of all participants is shown in Table 8 below. In the next section, I carry out the third stage of Bourdieusian analysis by mapping the position of agents in the field according to my research questions.

Table 8: Demographic data of participants

	Acorn medical school	Beech medical school	TOTAL
Age of student (n=91)			
18-25	66	25	91
Gender (n=91)			
Male	26	8	34 (37%)
Female	40	16	56 (62%)
Prefer not to say	0	1	1 (1%)
Year of study (n=91)			
Years 1-2	62	3	65 (71%)
Years 3-6	4	22	26 (29%)

Social class data (n=89)			
NS-SEC 1-2	41	20	61 (68%)
NS-SEC 3-5	11	3	14 (16%)
NS-SEC 6-8	12	2	14 (16%)
Ethnicity of interviewees (n=12)	Percentages from MSAR 2017/18 n=478	Percentages from MSAR 2017/18 n=1961	
White 3	60%	44%	
Black 1	17%	23%	
Asian 8	12%	20%	
Mixed 0	4%	7%	
Other 0	7%	6%	

Mapping position of agents in the field

In this section, I map out the objective structure of the position of the agents in the field and the capital they are utilising. I analyse this by generating codes and themes from a reflexive thematic analysis and applying these to my research questions.

I present these again below in Table 9 together with the main themes I have derived from the data for each of the research questions.

Table 9: Research questions and themes generated from the data

Research question	Themes
Do medical students from a variety of cultural backgrounds have a different experience of professionalism as they progress through medical school?	<ul style="list-style-type: none"> • Perceptions of fitting in at medical school • Challenges to habitus on arrival at medical school • Changing experiences on moving to field of care giving
Do negative experiences related to cultural factors affect the professional identity formation of students at medical school?	<ul style="list-style-type: none"> • Challenges to habitus leads to increased resilience • Role models and experiential learning become more important
What do students draw on to manage these negative experiences as they develop a professional identity?	<ul style="list-style-type: none"> • Maintain habitus expecting institution to manage the situation • Using resilience to deny their original habitus • Using impression management to present a professional persona

Although I am analysing the integrated data in a following the thread approach, I have tabulated below some of the responses to the questionnaire as a summary. It should be noted although I was focussing on the students' negative experiences, many students related positive examples that their culture had brought to their experience at medical school (Table 10)

Table 10: Summary of questionnaire results

Q7. Are you aware of social and cultural factors (e.g., ethnicity, social class, gender) affecting the experience of students at your medical school?	Definitely /probably Yes 77.2%	Not sure 17.7%	Definitely /probably No 5.1%
Q8. What was the effect of these factors on the students' experience at medical school?	Mostly positive <ul style="list-style-type: none"> ● Gender - 15.2% ● Social class – 24.1% ● Race/ethnicity – 16.5% 	Both positive and negative <ul style="list-style-type: none"> ● Gender - 32.9% ● Social class – 38.5% ● Race/ ethnicity – 38.0% 	Mostly negative <ul style="list-style-type: none"> ● Gender - 12.1% ● Social class – 15.2% ● Race/ ethnicity – 15.2%
Q9. Can you give one example where you have observed these factors having a positive effect in your medical school?	Diversity in general as a good thing = 20 comments	Positive comments Specifically citing: - <ul style="list-style-type: none"> ● Gender - 4 ● Social class – 21 ● Race /ethnicity - 20 	
Q10. Can you give one example where you have observed these factors having a negative effect in your medical school?	Negative comments Specifically citing: - <ul style="list-style-type: none"> ● Gender – 13 ● Social class – 26 ● Race /ethnicity -19 		
Q11. If you have noticed social and cultural factors, do you think they may affect the way students feel about themselves as professionals	Definitely /probably Yes 69.3%	Not sure 21.3%	Definitely /probably No 9.3%
Q12. Can you give more details of how these social and cultural factors may affect the student experience?	Positive comments Total - 2 Including support from ones' own social group and better understanding of ethical dilemmas	Negative comments Total – 46 Including general comments about not fitting in and imposter syndrome	Negative comments Specifically citing: - <ul style="list-style-type: none"> ● Gender – 1 ● Social class – 12 ● Race /ethnicity - 9
Q13. If you have noticed social and cultural factors, do you think they may affect the ways students develop their sense of professionalism as a doctor.	Definitely /probably yes 47.3%	Not sure 36.5%	Definitely /probably no 16.2%

Research question 1: Do medical students from a variety of cultural backgrounds have a different experience of professionalism as they progress through medical school?

In this section, I will look at participant data and discuss how the culture of the students has led to a variety of different experiences as they progress through the medical programme. In the first two years at medical school, students often link their ability to fit in and be accepted, to their social class, schooling and whether their parents were doctors. If they do not feel they fit in on arrival at medical school, they express this as a dissonance, recalling negative experiences. This is an example of the expectations of medical school challenging their habitus. As they progress through medical school, fitting in becomes less of a problem, with students in later years being sufficiently reflexive to articulate the adaptive changes they have seen in themselves.

As mentioned above, social reproduction or heritability is common in medicine, and is an aspect of culture that allowed the students to feel that they fitted into their field. In this study, students specifically mentioned having parents as doctors as a positive factor giving them additional cultural capital to navigate medical school.

'...because of my upbringing and how fortunate I was to have two doctors in the family. I feel like a lot of the things I experienced are familiar in a way... I've heard about them and about how the doctors think in certain ways so when I go on placement, and I talk to the doctors I don't feel there's a barrier there.' A6

Students also linked the medical parent advantage to their sense of professional identity formation as a doctor. Some students were able to express that observing the professionalism of their parents had paved the way for their own professional learning.

If their parents were not doctors, they often perceived this as a disadvantage and something that affected both their learning and ability to fit in.

'I didn't have any family in the healthcare profession at all and that wasn't the experience of everyone else. Some people had parents or other family members to help them through the process' B3.

It is significant that the students seemed to identify so closely with the accepted norm that having parents as doctors is not only beneficial but also necessary to progress through medical school. According to Bourdieu (1988), this is an example of symbolic violence following the doxa of social reproduction in the field. This impacts WP initiatives as there appears to be a pervasive message from my participants that children without doctor parents had an initial habitus that somehow put them at a disadvantage on arrival at medical school. Perpetuating the doxa that having a medical parent gives you cultural and symbolic capital to succeed in medicine runs contrary to the ambition to increase the numbers of students from lower socio-economic class backgrounds at medical school. This may explain some of the reasons for lack of aspiration to study medicine seen in schoolchildren, prior to entry to medicine (Greenhalgh *et al.*, 2004; Gore *et al.*, 2017).

Where students had difficulties fitting in at medical school, the responses of participants showed that social class and parental income were significant in forming these experiences. When participants were asked which particular factors had affected their experience, the commonest factors were, type of school attended, income of parents, geographical area of upbringing and social class at between 78% and 82% of respondents. Fifty per cent of all the negative comments in the questionnaire related to social class and many explicitly described the impact of reduced economic capital. Students mentioned the effects of a lower income both on ability to purchase equipment and books necessary for the course and to attend what they perceived as the right type of social events. This then impacted their ability to fit in, with one student feeling stigmatised because they were not able to purchase a more expensive brand of stethoscope.

The effects of these social class differences on their symbolic capital were clear as they discussed how this often made it difficult for them to be accepted at medical school.

'Arriving at medical school in my first year I definitely remember it being quite intimidating because I remember looking around and ...it seemed to be that a lot of people came from quite privileged backgrounds... a lot of students were privately educated... I got a sense of feeling like this is all very new and I was a bit of an outsider to it all'. B6, Year 5

This is significant for medical schools, particularly those with widening participation (WP) programmes. Students who enter a WP programme often do not receive extra social support once at medical school due to a reluctance to set them apart from other students and generate stigma. However, many participants in this study, from both WP and standard backgrounds, are reporting negative experiences related to social class in the early years at medical school. This suggests that there needs to be some support for students to navigate the differences in social class at entry to medical school.

Once students had reached the later years of the medical school, mostly in the field of care giving, they rarely mentioned social class as an issue suggesting that the duration of time in medicine may mitigate the influence of their original habitus. As discussed above, this fits with the idea that students use the capital available to them to generate a medical habitus. For the students who are able to generate this new habitus, this afforded them the opportunity to fit in and be accepted at medical school. Student B6 goes on to say,

'Now on placement, my firm are a random group of people that I didn't even know before... It is nice that now there has been a bit more mixing ... that can be quite surprising because it could be people that you really didn't expect that you would get on very well with'. B6 Year 5

Students related how their diversity actually helped them in navigating the clinical years.

'Being from a working class, diverse background in East London has helped me relate to patients from similar backgrounds whilst on placement'. S71 Beech, year 3-6

Participants often used the word maturity to describe how they approached the later years, suggesting that these students have recognised the change that has occurred. As they progress through medical school they are taking on the habitus of medical professionals, and their social class origins become less important.

As they navigated their arrival at medical school and managed any challenges to their habitus, students reported a disparity in how they were now accepted by friends and family at home. Although now more comfortable at medical school, they no longer felt accepted by their original peer groups at home and this was an additional source of stress. Some students reported embarrassment at conservative or racist attitudes expressed by their parents and were unsure how to deal with these.

'We're a very white family, and my dad's from up north, and they're not as, I don't know if politically correct is the right word, but they're very blunt, and they ask questions that are a bit inappropriate these days'. A3 White British

This is significant as this demonstrates that these students are utilising the social capital to change their original habitus and help them fit in at medical school but may leave them feeling adrift and not belonging to a particular social grouping, as reported by others (Beagan, 2005). One Pakistani student who attended a state school and whose parents were unemployed, illustrates this in the comment below,

'I think it's quite pronounced when I meet my friends from back home, you know, from school, who I knew before I was a doctor. When I hang out with them again, I feel like I've changed a lot'. A5

Bourdieu (1999 p. 618) recognised this phenomenon and termed this group who are in the process of changing their habitus as 'excluded from the inside'.

As they moved into the field of care giving, many students related experiences due to gender and racial discrimination. With medical school cohorts being almost 60% female, I was not expecting to see high levels of gender discrimination in my data. However, gender issues made up approximately a quarter of the negative free text comments in the questionnaire and were also commonly mentioned in the

interviews. These were often presented as microaggressions, as can be seen from the comments below.

'My friend was wearing a dress, a red dress, and one of the consultants was – she was trying to get into a roomand he basically said, "Oh that's quite a dress. I'll let you in for that." And then, turned around to his colleague and was like, "Am I allowed to say stuff like that anymore? Like, I don't think I am, but I did anyway." A5 female

'I've had male consultants refer to my male colleagues as, you know, young doctors, and then sometimes they refer to us as nurses. Which I hate. Like, it drives me mad!' A3 female

Being male seemed to supply symbolic capital in the clinical placements, particularly in certain male dominated specialties in a way that was not apparent in the medical school environment. Female students reported male students being treated more seriously by some male consultants in a way that affected the teaching quality.

'I think coming into clinics where a physician will think that their speciality is not cut out for a woman will mean they won't provide the same standard of teaching.' S2 Beech female

Conversely, some of the male participants in the interviews described being discriminated against by midwives and patients in obstetric placements, as they would frequently be asked to leave the room during a delivery.

'Well, I suppose one area where I have seen female students being treated differently is in obstetrics and gynaecology, but I think that's something that's understandable and it is something that can be explained You know if I wanted to, I could have gone on to be an obs and gynae doctor, but you know....' B5 male

They were quick to stress that this was not an issue for them personally and stressed the rights of choice of the female patients although one student went onto say it would affect his future career choice. This is another example of symbolic violence contributing here to the doxa of feminisation of certain specialties. However, male students are still expected to achieve the same curricular outcomes as female

students and if they are being disadvantaged in their ability to achieve these outcomes, this is something that should be considered.

With the current widespread discourse of racism in medicine, I did expect to hear about incidences of racial discrimination from my participants. In the questionnaire, just under one fifth of the negative comments described race and ethnicity as an issue. In the interviews, several students went into more detail about their experience of racial discrimination in clinical placements. When describing the actions of the consultants this was again more likely to be in form of microaggressions such as not directing a question to them because their name was difficult to pronounce or failing to learn their name.

'Sometimes it's kind of 'oh that's an interesting name'. I am like, I don't really know what you mean by that, but it doesn't sound like insinuating anything too nice'. B6

Amongst the students, whiteness was seen as providing symbolic capital in the field of care giving, in a way that was less apparent in the field of education.

'I'm white, so I don't really see as much racial prejudices, I guess, but I'm sure there certainly are some'. B2

Some white students were not aware of racial discrimination but others had observed it taking place towards other non-white students. Students in the field of care giving were especially distressed about overt racism expressed by patients, particularly as they seemed to be unsure about how to deal with it. They had been taught to be patient-centred and thought that challenging a patient for racist comments could be seen as unprofessional.

'I see a number of quite racist comments from patients. And obviously, that's quite difficult it's the question of where you stand, and what you are and aren't allowed to say to a patient. But things like, I hate saying this, but they don't want a non-white person in the room. And they ask them to leave, and it's a very uncomfortable situation for everyone'. A2 White British

There seemed to be a variety of responses from the consultants leading the teaching with some dealing with the patient attitudes in a way that supported the student and ensuring that they remained in the teaching setting. However, other consultants, including one from a BME background, seemed to collude with the patients and not challenge the overt racism.

The intersectionality between class, race and gender was present in the findings but as discussed above, demonstrated some complexities. It was not necessarily seen that minority ethnic groups, lower socio-economic class and gender all intersected to compound a perceived disadvantage. For example, looking at the intersectionality between social class and ethnicity, the students from ethnic minorities, who had parents as doctors or who had attended private or grammar schools, felt this was more important in helping them to fit in at medical school than issues of their race. The presence of this social capital seemed to minimise the effects of ethnicity in the field of education. The sample size was too small to detect any of the previously mentioned negative experiences of white male working class students in education. There was also evidence of intersectionality between gender and ethnicity. Issues relating to sexual discrimination were mentioned by participants of every ethnicity but the microaggressions seemed to be more commonly cited by BME women.

As has been noted in other studies (Castellani & Hafferty, 2006; Monrouxe & Rees, 2017), students expressed dissonance at how their experiences differed from what they had been taught to expect by the medical school. This suggests that students are largely taught within the discourse of diversity in the medical school but experience the discourse of standardisation and a lack of tolerance for difference, in the field of care giving.

'I feel within the medical school, it wouldn't be an issue, I've never noticed it [racism] being an issue with our professors, or between different students. The only time I think that's ever brought up is with patients and normally, white patients'. A3

This is the type of dissonance that may lead to moral injury as they try to reconcile these negative experiences which are in direct opposition to what they have been taught in the field of education.

This section has explored this research question by showing that students from a variety of cultural backgrounds have a range of experiences and these differ in nature as the students progress through their medical programme. Social class issues and threats to their habitus, including re-negotiating where they now stand with their habitus developed in early life, are prominent on arrival at medical school. There is a notable emphasis on the impact of parents as doctors particularly in the early years of medical school. As they progress through their education, some students experience discrimination in the field of care giving that is in conflict with what they have been led to expect in the field of education. It seems likely that the field of education and the field of care giving are delivering different messages due to the disparities in the prevalent discourse. In the next section, I consider the effects of these negative experiences on the professional identity formation of the participants.

Research question 2: Do negative experiences related to cultural factors affect the professional identity formation of students at medical school?

Although students related some positive experiences linked to their culture, I am choosing to focus on the negative experiences in the data set as these were more frequently reported. As mentioned above, social class concerns were particularly prevalent in the field of education as part of the initial experiences and there was evidence this was impacting the students' sense of professionalism. When asked to give more detail about how their professionalism may be affected by culture, many comments related to issues with confidence.

'Students may not have the confidence from medical school due to not feeling accepted. This can make them feel quite under-confident in their decisions affecting their sense of professionalism as a doctor' S45 Acorn.

Two participants in the questionnaire specifically mentioned the *imposter syndrome* as something they experienced when not fitting in at medical school, suggesting that this lack of confidence was affecting their perceptions of how they appeared to others.

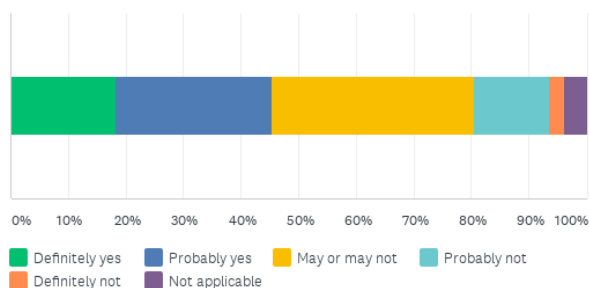
These negative experiences delivered by individuals in opposition to the standard medical school teaching, were upsetting to the students, as they seemed to expect a higher standard of behaviour from medical professionals.

‘She just turned round and asked me, “What’s it like being a person of colour in [name of city]?” And I was quite shocked by that. I just didn’t expect somebody in a professional setting to ask that!’ A1

In the questionnaire, 45% of students said social and cultural factors had ‘definitely’ or ‘probably’ affected their professional development as a doctor compared to 16% of students who thought they had ‘definitely’ or ‘probably’ not affected them. (See Figure 4 below).

Fig. 4: Student views on how cultural factors have affected their professionalism

Q13 If you have noticed social and cultural factors, do you think they may affect the ways students develop their sense of professionalism as a doctor.



Drilling down further into the effect of these negative experiences on their professional identity was challenging as some students were not easily able to express what professionalism meant to them. They ascribed the development of a professional identity to a natural maturation process.

'I do feel a lot of people do change, but I don't think that's because they've become professional, I think it is just maturing over five years of the course,... they as a person would still have changed into a possibly more professional person just because of the course'. A6

Some students expressed a view that professionalism was about communication or appearance and the way they dressed, but a common theme related by students was a link to behaviour with the patients.

'I think so much about being professional is, being a really good communicator, and a good listener, and explaining what you're doing really well to the patient and asking them questions. And then, sensing what the patient is feeling. So, if a patient is unsure even if they're not saying it, picking up on that. I think that's quite professional because it means you're in tune, and you're really thinking about what the patient needs'. A3

This may be why dealing with racism from a patient is so difficult for the students. Their sense of professionalism is strongly linked to how they communicate and behave around the patient. If they are then challenging a patient for holding unacceptable attitudes, they feel that this is in conflict with the patient-centred persona aligned to medical professionalism that they have been taught to adopt in the field of education.

One thing that's particularly difficult is that patients are the consumers of the NHS, so I think it can be quite difficult to have a patient who is say prejudiced. People sometimes don't feel like it's their place to tell them off, and yet, there should be some sort of conversation there that does happen. B2

Dealing with incidences of discrimination from a patient may be discussed in reflective groups but is often not addressed as a curricular topic. However, doctors and medical students do regularly challenge patients over unhealthy lifestyle habits such as smoking and obesity and they are taught how to do this as part of the curriculum. This may be an area that could be formally introduced in the curriculum.

A common theme from students in the field of care giving was that of developing resilience following on from these negative experiences, which they seemed to feel was synonymous with their sense of professionalism.

'I think it's definitely making me more resilient, because I knew something like this would happen, and I think you become used to it. But, in a professional setting, I think it does make you stronger... So, I guess that idea of resilience with patients is developed'. A1

Many students expressed that resilience was a necessity to navigate their progression through medical school, perhaps because in recent years this is something we have often stressed in professional education. Almost all the students valued the professionalism teaching they had received in the field of education. However, they said it was the practical experience in the field of care giving, rather than this explicit teaching that had increased their sense of professional identity. The students who had reduced clinical exposure due to the COVID-19 pandemic were concerned that this would impact their ability to act as a professional.

'Yes, definitely knowledge comes into it but more so how to act as a doctor, what makes a good doctor... I think knowledge and stuff you can pick up over your life anyway and you are always going to be learning, you are never going to be able to know everything but sort of how to interact is a much more important skill which can only be learnt once you've experienced it'. B5

In common with other studies (Lempp & Seale, 2004; Hafferty & Castellani, 2009) students also mentioned role models as being particularly beneficial to their sense of professionalism. There was a perception that being able to observe someone being professional transcended the need to describe in words what was required from a medical professional.

'I think it's just a case of trying to find doctors who I can look at and say I want to be like you and consistently of going into placements, learning from them... how they handle certain situations, just literally learning from it, like I would [a] knowledge base'. B5

This is linked to the hidden curriculum or the effects of culture in the workplace transmitting the values of the institution. One student specifically mentioned the hidden curriculum when describing that the professionalism teaching was at odds to what they had experienced in practice.

'It's quite hard right, because we get a lot of teaching in clinic, around professional practice, which... is more likely hidden in the curriculum. So, it's something quite hard to address. It's something I am still exploring and trying to grapple with'. B1

I also sensed that students did not necessarily perceive these experiences as negative but as a learning experience from which to grow and develop. These were the experiences that often triggered their desire to become more resilient. Rather than negative experiences, it may be better to call them events that challenge their habitus. This is important when considering the actions of students from diverse backgrounds in managing their professional identity. Although some may experience these events as dissonance leading to moral injury, others may consider this as a 'critically intensive learning period' necessary to make the transition into an embodied professional (Kilminster *et al.*, 2011). This is an important distinction when considering how students are managing these challenges to their habitus.

In this section, I have explored this research question by discussing how the participants related challenges to their habitus to their developing professional identity. I have discussed how they are aware of the hidden curriculum and explicitly use role models to help develop a sense of professionalism. They are distressed by witnessing behaviours from their teachers that they do not expect and talk openly about the need to develop resilience as a way of becoming more professional. In the next section, I explore the choices that students have to draw on as they manage the experiences that challenge their habitus.

Research question 3: What do students draw on to manage these negative experiences as they develop a professional identity?

As mentioned above, culturally diverse students may have a greater likelihood of experiencing events that will challenge their habitus, due largely to elements of the hidden curriculum delivering messages from the discourse of standardisation. They then have choices about how they will manage this situation with students likely to be drawing on varying strategies on different occasions. They can (i) maintain their original habitus, expecting the institution to change to manage the situation or they can (ii) absorb the dissonant feelings and employ resilience to deny their original habitus, or they can (iii) employ resilience and use social constructivism to influence the situation and their emerging professional identity. I discuss these three options in more detail below.

Maintaining their original habitus

Some diverse students respond to challenges to their habitus by remaining true to their identity. They have internalised the messages from the discourse of diversity and maintain their original habitus even if this is in conflict with requirements of the medical school. Rather than seeing a need to change their own behaviour, they define the situation as unfair and expect the institution to take steps to resolve any issues.

'I am yet to meet someone who isn't from private school. I find this unfair that medical schools are biased in favouring private school education' S56 Acorn

This was not a prevalent view amongst my participants but was present in some of the student responses to perceived discrimination. Some students expected more support from the institution and were disappointed not to receive this. There were incidences where consultants had stood up for them and called out racial discrimination, but others reported a lack of action, reinforcing the doxa in the field.

'The university failed to act on the Islamophobic comments. I do understand it was probably a difficult position for them to be in. But at the same time, as a Muslim student, it's not something that's positive. It's not reassuring'. A4

Students taking this view often saw themselves as victims of the racism and sexism in the system and were then not able to speak positively about their medical school or medicine itself. They frequently seemed to be suffering moral injury and expressing the cynicism reported in students at medical school.

'Felt and heard about racism in clinical placements, uncomfortable to arm yourself with the idea that you may be racially abused going into training, as well as more covert racism in teaching practices.' S78 Beech

Students are supported in this stance by various initiatives emanating from the discourse of diversity and designed for institutional change such as the whistleblowing policy and the Duty of Candour (GMC, 2015) together with the BMA racial harassment charter (BMA, 2020b). Whilst following these policies, students can adopt a victim status, passively expecting the medical school to manage their negative experiences. However, this may be risky strategy for the students where the discourse of standardisation has yet to catch up with these policy changes and the medical school still expects conformity. These students may be deemed rebellious and unprofessional and could eventually leave medicine through a Fitness to Practise process.

The opposite of passive acceptance and maintenance of habitus is students actively trying to change their identity and deny their original habitus. This can be mediated through resilience in response to a challenge to their habitus and this is discussed in the next section.

Denying their original habitus through resilience

I have mentioned above how students became more resilient in response to a challenge to their habitus. However, some students went further to say that

resilience became their main coping strategy as they denied their original habitus and changed to conform to medical school expectations. Students talked about the conflicts caused by having to fit a professionalism view that was distant to their own and would equate to a change of habitus.

It may force some students to fit a professional mould, stifling any way to have their personality and style be shown during clinical practice. This can cause intense internal conflict for some as they may feel that they are not hitting the mark/ not up to standard'. S73 Beech

One student from a BME background spoke about the assumptions from his family that he would 'tough it out' despite experiencing a second year which for him was psychologically and emotionally challenging.

'Even if medical school is hard, you've just got to tough it out, it's like if you got into medical school, you've clearly shown that you've got the intellectual capacity and therefore you've got hard work. So, if people do ask how you are doing at medical school they sort of do assume that you should be doing fine because you got in in the first place. It was more you just got to get through this, you can do it'. B5

There is increasing talk in medical education, seemingly linked to the discourse of standardisation, about expecting students to become more resilient to cope with changes in the workplace (McKinley *et al.*, 2020; Zwack & Schweitzer, 2013). The development of resilience is often linked to an increased cynicism in medical students which may be expressed as dark or callous humour, an example of the hidden curriculum (Wear *et al.*, 2006). Students may use this type of humour to defuse situations or deny exploring the true emotions attached to a negative experience and there was evidence in the interviews of the presence of this type of humour.

The student comments seem to suggest that using resilience to manage the challenge to one's habitus and to deny their original habitus is leading to dissonance described by one student as an 'intense internal conflict'. These students would appear to conform with the rules and progress at medical school, but at a personal

cost. It was possible to see how this strategy could lead to moral injury and adverse mental health outcomes in the students. However, analysis of the data seemed to show a third possible coping strategy discussed below.

Using social constructivism to present a professional persona

As I analysed the data it became clearer that many of students who responded to the questionnaire and interviews and had experienced challenging situations were actively managing this through a form of performance management. Often, they would commence talking about the need to be more resilient and then say that they had developed a parallel professional persona to help them deal with the situation.

I definitely wear different hats in different settings. So, I've got casual me when I hang out with friends. And I've got professional me, who I use when I'm around patients, and doctors, and stuff. But I think, in terms of resilience, I've suffered with a few mental health issues since I was very young so, I've always, when things were tough, I just put on a mask to get through it. And that's definitely been quite helpful when you're getting yelled at by a doctor'. A2

One student mentioned her role as a president of a student society and how other students noted that she was different in this role to her other activities at medical school. This is an example of Goffman's impression management in practice and would be classed an unofficial frontstage activity in Sinclair's (1991) ethnographic description of medical school life (see Figure 2, page 55).

This same student continued to relate an anecdote where a consultant in the hospital had actively encouraged them to present themselves in a different way.

"The renal consultant, she was female, she was like, "As females we already get saddled with enough, sound confident in what you're saying" and after that I tried to do that, and it does make people think you know what you're talking about more' A5 female

This is an example of a clinical teacher advocating the principles of impression management to avoid reproducing the doxa in the field. This is likely to be prevalent

as part of the hidden curriculum with role models having a powerful voice to guide students to navigate certain paths of behaviour.

Students are frequently encouraged at medical school to role-play difficult conversations and there is a sense that they are familiar with the process of putting on an act. The interview participants were open about wearing 'different hats' and using impression management by rehearsing their actions on the backstage to prepare them for the frontstage. They mentioned they would actively use this strategy when encountering negative experiences at medical school. This would then allow them to rationalise the challenges to their habitus and manage their emerging professional identities as they progressed through the course.

This strategy of social constructivism seems to be employed by the most reflective students who are aware of the competing discourses and hidden curriculum. Without expressly stating the fact, they are using this strategy to combine the discourses. However, there is a question about whether this is beneficial for professional identity formation as a whole and will create the type of medical professionals we are aiming to develop. Since we expect probity and integrity from medical students as part of professionalism, impression management could in itself be unprofessional. It may lead to students and junior doctors pretending to have skills they have not acquired and discourage them from asking questions for fear of exposing their ignorance. It may perpetuate the medical hierarchies that can cause risks to patient safety and I will return to this in the discussion.

One student told me about using a fake persona in the field of education to manage impressions with the medical educators.

'They make you reflect and reflect, and reflect, and then you only get a good reflection, if you cry in your reflection session, then that's it you've passed, you've got an excellent. It's kind of a running joke. So, I know a lot of people that have faked it'. A5

However, this student went onto say *'they actually started becoming a lot more emotionally intelligent'* demonstrating an eventual beneficial effect. This suggests that practising the skills of professionalism through social constructivism on the backstage is necessary to achieve a fully formed frontstage professional identity.

There is a sense that remaining clear that these are performances and not to be passed off as depictions of real life is key to maintaining the integrity of this process.

This section has explored the third research question by discussing the actions of culturally diverse students as they experience challenges to their habitus and looks at three possible scenarios, as observed from the data. They can maintain their original habitus following the messages from the discourse of diversity and expect the institution to manage the situation, but this can lead to a victim status and subsequent moral injury (Gollwitzer *et al.*, 2015). They can deny their original habitus as expected by the dominant discourse of standardisation, using resilience to manage their dissonance but this may also lead to moral injury. Although both of these scenarios may take place as students progress through medical school, the more reflective students seem to be drawing on social constructivism as they negotiate the messages delivered by the competing discourses and form their professional identity.

This data analysis chapter has discussed the data collected in this study from the questionnaire and interviews and presented the initial analysis using a Bourdieusian three-stage field analysis. The first stage of 'position of the field in relation the field of power' was discussed above in Chapters 2 and 3. In the second stage, I have presented the demographic data and analysed the individual agents and their habitus. In the third stage, I have used a reflexive thematic analysis linked to my research questions to map the position of the agents in the field and their use of capital as the students progress through medical school and attempt to take on a medical habitus.

When looking at how the students manage the threats to their habitus, I have observed three differing strategies depending how they choose to interpret the prevailing discourses and explore that the strategy that seems to combine the discourses draws on social constructivism and performance management theories. Students are fully aware of the messages being delivered by the competing discourses and employ resilience to allow them to remain in control as they use the backstage to rehearse the skills necessary for their frontstage professional identity. Although an observed strategy, the question about whether this is beneficial to

professional identity formation will be discussed in more detail in the following chapter, drawing on additional literature made relevant by the findings from the data.

Chapter 6: Discussion of findings

'The conscientious professional ducks and dives amid multiple discourses... the challenge to professionalism lies in the handling of multiple discourses' (Barnett, 2008 p. 200).

In the introduction in chapter 1, I introduced the issue of competing discourses in medicine and how these influence all facets of medical education but particularly contribute to the debate around medical professionalism. The positivist discourse of standardisation suggests that students need to demonstrate professional behaviours as part of the 'doing' of professionalism, whereas the interpretivist discourse of diversity suggests that students need to be socialised into a professional identity as part of the 'being' of professionalism. In parallel, a drive to widen participation at medical school is leading to an increasingly diverse medical student population. These students are granted access to medical school through the discourse of diversity but are frequently challenged by messages from the opposing paradigm delivered by the hidden curriculum. Diverse students who may be struggling on arrival to fit in at medical school due to challenges to their habitus, often experience further threats to their identity in clinical placements where they can encounter overt racism and sexism.

In this study I have collected data from students from a variety of cultural backgrounds and explored their views on medical professionalism. I then apply the theories of Bourdieu to consider how the students use their social and cultural capital to mould their habitus as they progress through medical school and develop their emerging professional identities. I give examples from the data of the presence of symbolic violence, which is responsible for reproducing the doxa in the field and leading to experiences that challenge the habitus of the diverse students. I then consider the choices of students in managing these negative experiences due to their culture, and through the use of Goffman's dramaturgical theories suggest that some students are using social constructivism to manage their dissonance as they encounter the competing discourses.

In this discussion, I return to the research questions to explore the possible origins of the differing experiences related by the participants, how they feel this is affecting their professional identity formation and the coping strategies they are drawing on to manage the challenges to their habitus. I discuss how the competing discourses in medical education appear to impact the widening participation (WP) efforts to increase the diversity of the medical student population. Messages delivered by the hidden curriculum seem to challenge the WP agenda and adversely affect the professional identity formation of the diverse students. As discussed above in the reflections on methodology section (p. 110), this is a small pilot study with relatively few participants. My constructionist approach means that I have produced a version of the truth, but when discussing these findings and the implications that arise from them, there is an element of uncertainty that would need to be explored with further research.

This discussion also introduces new literature that I have been able to explore following insights derived through the research process. I discuss other work on students' ability to fit in at professional school and the sources of capital that they draw on as they develop an expert status, linking this to the medical habitus in medicine. This additional lens to view capital, helps to explain some of the intersectionalities seen in this study. As students move from school into medical school and then progress from the field of education to the field of care giving, I relate this to the literature on transitions in medical education. The discussion continues to consider the data on experiences that challenge the habitus, discussing relevant literature on resilience and empathy and exploring new concepts of resilience at medical school.

Fitting in

The first research question refers to different experiences of professionalism encountered by students from diverse cultural backgrounds. Some participants in this study were positive about their cultural diversity experience and appeared to be coping well at medical school. This is echoed by Costello (2005) in her ethnographic

study of students at professional school. She performed a constructionist study of law and social work students and describes those who feel comfortable at professional school as *identity consonant*.

'Some students arrive at professional school with the contours of their identities already shaped in a manner appropriately streamlined so that the grains of socialisation slip smoothly around them' (Costello, 2005 p. 117).

At medical school, most students from the field of education seemed clear about what would help them to fit in on arrival, particularly citing higher social class and type of school attended. A prevalent theme was having doctors as parents, which seemed to provide symbolic capital and a natural identity consonance. However, an important finding from this study is that students from a variety of cultural backgrounds arrive at university feeling that they do not fit in with life at medical school and this was apparent at both of the schools studied. Costello (2005) described those who did not fit in at professional school as *identity dissonant*.

One of the psychological effects of the dissonance felt by those who did not easily fit in at medical school was termed *imposter syndrome* by some of the participants. Imposter syndrome is characterised by an experience of feeling incompetent and of having deceived others about one's abilities, with a persistent fear of being exposed as a fraud (Langford & Clance, 1993). Students who experience this are likely to suffer from dissonance and moral injury. It is known to be particularly common in the high-pressure environment of medical school and postgraduate studies (Chen, 2020; Russell, 2017) often without any objective evidence of a skills deficit (Clance & Imes, 1978). It should be noted, although imposters are usually linked to putting on an act, imposter syndrome is a psychological effect of a challenge to the student's habitus and not linked to performance per se. This is distinct from the agentic impression management theory presented by Goffman, where the students are actively choosing to put on an act and present a different persona.

The identity dissonant students in this study attributed a cause to their lack of symbolic capital, for example in not having medical parents. This assumption of a

social norm is an example of symbolic violence to reproduce the doxa in the field (Bourdieu, 1988). This is relevant to the WP agenda where there is much discussion about how to encourage certain underrepresented groups to apply to medical school (Gore *et al.*, 2017; Greenhalgh *et al.*, 2004; Mathers & Parry, 2009). The strong message of social reproduction in medicine may be deterring certain groups such as white working class boys and Afro-Caribbean boys from considering medical school as an option (Krstić *et al.*, 2021). Many medical schools deliver outreach activities at local schools in an attempt to widen participation, but I am unsure whether the issue of social reproduction is actively addressed in trying to encourage schoolchildren without medical parents to study medicine.

In addition, students are receiving mixed messages from the schools themselves about what constitutes excellence on admission, in something that has been termed the *hidden curriculum of admissions* (Razack *et al.*, 2015). My own medical school claims to be promoting diversity but enacts this with a summer school programme to ensure WP students submit applications that mirror those of the mainstream students. This is not celebrating the difference that students from different cultures can bring to medical school but ensuring they all reach the same high standard for admissions. Razack and others (2015) cite one of the explanations for this hidden curriculum in admission processes is the unwillingness for medicine to understand its own part in creating the problem. Diversity is presented as something new and reified and as a means to achieve social accountability through the superficial characteristics of class, race and gender (Razack *et al.*, 2015). Medical schools are often not reflexive about their own hierarchies and discourses and this may be perpetuating the situation (*ibid.*).

This study discusses how issues related to lower socio-economic class seemed to be significant for large numbers of students on arrival at medical school. In my experience, medical schools and the students themselves are unwilling to highlight their WP status once they have gained a place at medical school. This fear of identifying certain individuals means that timely support is often not provided. Ideally, specific measures could be put in place proactively before these students

experience difficulties, but due to an unwillingness to stigmatise these groups, there is often little focused activity to support these students.

I have used Bourdieu's theories of embodied family habitus and capital to describe the situation of students from lower socio-economic groups as they enter medical school. Other authors have also tried to describe the types of capital that may be available to schoolchildren aspiring to move into higher education and these theories may better describe the intersectionalities that exist between different protected characteristics. Robb and others (2007) consider the types of capital available to children aspiring to study medicine and additionally explore the intersectionalities present within culturally diverse groups. More specifically children may be influenced by *identity capital* (Côté & Schwartz, 2002) and *ethnic capital* (Modood, 2004).

Identity capital, similar in many ways to Bourdieu's concept of social and economic capitals, refers to an individual's ability to make use of a set of resources such as qualifications and self-esteem. Students draw on this capital to transcend barriers such as social class and race and negotiate a successful life strategy (Côté & Schwartz, 2002). It is possible that some diverse individuals may have qualities that mean they are better suited to negotiate their time at medical school. This is sometimes referred to as resilience but it remains unclear how these qualities can be detected in a school leaver applying for a place in medicine.

Ethnic capital refers to the particular drivers that immigrants may experience as they progress in education (Modood, 2004). Examples include knowing they need to work hard to achieve against the odds and being driven to succeed by a sense of injustice (*ibid.*). Immigration is another reason that occupation may be a poor measure of social class; immigrants may have had a high status as professionals in their home country but as an immigrant are currently placed in a working class occupation (Robb *et al.*, 2007). It is this ethnic capital that may be contributing to the intersectionalities between race and social class seen at entry to medical school. Although working in a lower social class occupation, immigrants may have aspirations for their children to succeed as professionals in their adopted country

(Seyan *et al.*, 2004; Wilson *et al.*, 2011). My data seems to agree with this picture, as it includes BME participants from all social classes and leads to an inconsistent picture about what constitutes a WP student.

Transitions

The second research question refers to whether negative experiences affected the professional identity formation of students as they progressed through medical school. As discussed earlier, all students in this study, including the ones who did not initially feel that they fitted in, seem to use the available social and cultural capital to change their habitus as they move from the field of education to the field of care giving. As they become more prepared to be doctors, they begin to adopt a medical habitus and learn to develop a 'feel for the game' (Bourdieu, 1990b p. 66).

There is a debate about whether it is necessary for medical students to develop a medical habitus to become a practising doctor. Supporters of the discourse of diversity would argue about issues with conformity and a need to express individuality (Frost & Regehr, 2013; Razack *et al.*, 2015). However, the practice of medicine will generally require certain standards and rules and it is how these are presented that becomes the important issue (Hodges, 2010). Sinclair (1997) and Brosnan (2009) felt medical habitus was a vital part of the professional socialisation process and I would suggest that adopting a medical habitus is the means by which professional identity is internalised.

There is a broad literature considering the perceptions of medical students as they move into and through medical school, as a series of transition points (O'Brien *et al.*, 2007; Surmon *et al.*, 2016; Teunissen & Westerman, 2011). Transitions are not discrete moments in time but a 'process whereby an individual undergoes a shift from one set of circumstances to another' (Bassett *et al.*, 2018 p.103). This includes movement from school to medical school, from the university based to the clinical parts of the course, and then into the workplace (*ibid.*). The transition from pre-clinical to clinical parts of the course is known as one of the key areas where

students can encounter difficulty (Teunissen & Westerman, 2011). Transition to the clinical clerkships was considered at an early stage by Becker in *Boys in White* (1961) where students had difficulty forming relationships with senior doctors and other colleagues as they moved onto the wards (Becker *et al.*, 1961).

Widening participation students are often not considered in terms of transition, although there have been some descriptive studies that consider the transition of BME and first-in-family medical students as they enter the clinical environment (Brosnan *et al.*, 2016; Isik *et al.*, 2021; McKimm & Wilkinson, 2016). Female medical students seem to have particular difficulty at transition to the clinical environment as they negotiate their relationship with the nurses on the ward (Babaria *et al.*, 2009). These female students often become confirmed in gender stereotypes of being more caring and agreeable, another example of Bourdieu's symbolic violence (Bourdieu & Wacquant, 1992). However, beyond noting that these diverse students have issues and suggesting they need more support, there are few practical solutions presented in these studies.

Although the process of transition from pre-clinical to clinical students has been well studied, it is contested whether it is the responsibility of the student or the institution to manage the transition process (Surmon *et al.*, 2016). There is a broad agreement that transition is part of professional socialisation with student experience having the most impact (*ibid.*). In common with many schools, we hold a transition courses for students entering the work environment after the final year, but there is little formal preparation for students arriving at medical school or progressing into the clinical years. When preparing students for transitions, it can be challenging to reproduce authentic experiences and achieve a true community of practice (Lave & Wenger, 1991).

In some cases, a degree of dissonance could be necessary as a trigger to help students learn. It may not be possible, or desirable to completely eliminate the discomfort students feel at transition. Kilminster and others (2011) have reframed transitions at *critically intensive learning periods* and suggest the dissonance may be

vital to allow students to make the necessary changes and form the relationships to succeed. This is significant as it suggests that smoothing the explicit transition points may not be of the most benefit to students and they need to experience some dissonance to feel fully prepared. This puts the emphasis back on the student rather than the institution to manage the transition.

It may also help to explain why the students in this study do not necessarily see their experiences as negative. Some authors regard this as a failure to be reflexive about their experiences, with students tending to accept the dissonance and stress as a necessary part of their training rather a commentary on the current social and political discourses (Brosnan, 2009; Sinclair 1997). These are students who were not coping well and some students in this study were likely to be of this mindset. However, other students employed a coping strategy to use these experiences in a form of social constructivism to develop their own professional identity. Costello (2005) also recognised these two groups in her study of students at professional schools. Those students who were not coping with the challenges to their habitus were termed *negatively identity dissonant*, whereas as those who recognised that they did not fit in but were developing coping strategies were termed *positively identity dissonant* (Costello, 2005).

Resilience

The third research question relates to the coping mechanisms of students as they manage their negative or challenging experiences. If, as suggested, students need to experience some dissonance in order to develop learning at these transition points, they also need tools to help them manage this dissonance and negotiate a path through medical school. Traditionally resilience is posited as a tool to help medical students manage the negative experiences and uncertainty as they progress through their course (McKinley *et al.*, 2020; Zwack & Schweitzer, 2013). The GMC defines resilience in medical students as an 'ability to adapt and be resourceful, mindful, and effective in complex, uncertain, or stressful situations' (GMC, 2016c).

However, resilience has also been noted to be linked to an increase in cynicism and reduction in empathy of medical students (Hojat *et al.*, 2009; Oliver, 2017).

The links between resilience, cynicism and empathy are complex with a lack of agreement about the causation. Cynicism has been directly linked to the development of the medical habitus and arises due to the conflict between the original idealistic disposition of the student and the need to form a competent disposition to succeed (Brosnan, 2009; Luke, 2003 Sinclair 1997). Several authors suggest that an increase in resilience is necessary to combat this cynicism that may lead to burnout (Howe *et al.*, 2012; McKinley *et al.*, 2020; Wright & Richmond Mynett, 2019).

However, others feel that an increasing expectation of resilience from medical educators will lead to reduced empathy and possibly increased cynicism in the students. This reduction in empathy may be due to factors such as a high workload, time pressure and a competency based curriculum, without consideration of the social structures underpinning those elements (Hojat *et al.*, 2009). There is also concern that expecting the students to be resilient, places the onus on them to be responsible for managing their own mental health (McKinley *et al.*, 2020; Oliver, 2017). If they are unsuccessful at medical school, then they could blame themselves for being insufficiently strong (*ibid.*).

Promotion of resilience is often cited as a way of enabling medical students to cope with uncertainty (Cooke *et al.*, 2013; Wright & Richmond Mynett, 2019). Clinical and professional uncertainty is thought to be a cause of dissonance and moral injury in students and newly qualified doctors (Russel *et al.*, 2021). Despite the GMC, *Outcomes for Graduates* requirement to train doctors for complexity and uncertainty (GMC, 2018a) there is little practical advice about how this should be achieved (Fox, 2013, Russel *et al.*, 2021). Promotion of resilience is often suggested as a post hoc strategy, with all the risks mentioned above, rather than something pro-active. The suggestion that students could be actively managing uncertainty through a social

constructivist process, as suggested in this study, may have some practical applications.

The negative aspects of resilience mean that more nuanced approaches have been suggested in recent years. For example, there is an increased focus on advocating student wellbeing with activities such as yoga and mindfulness rather than explicitly promoting resilience (Peters *et al.*, 2018). Younie (2021) has introduced the term *flourishing* in medical education in preference to resilience as this puts emphasis on personal growth of the student rather than focussing on deficiencies. She describes the use of medical humanities and creative enquiry to develop metaphors that help the students make sense of their experiences. Others have explored the benefits of encouraging person-centredness in medical students through reflective small group activities to help learners make sense of their emotions and underlying values (Bansal *et al.*, 2021). However, these new approaches still focus on the individual student to effect a change.

Others feel that promoting individual development of resilience is taking the focus away from a broken system (Dean *et al.*, 2019; Oliver, 2017). Rather than encouraging students to absorb the negativity and find ways to become stronger, we should be demanding changes from the institution (medical school or hospital Trust) that will allow the students to cope (*ibid.*). The institution needs to take steps to deal with incidences of discrimination and protect the diverse individual. This is a persuasive argument and one that many medical schools have been advocating in recent years, but in practice, this approach presents challenges and is again subject to messages from the opposing discourse.

A need for the system to change is promoted by the discourse of diversity and is aligned to the 'maintaining original habitus' that some students were following in this study. However, the opposing discourse of standardisation leads to a resistance to alterations in the social system with changes only occurring slowly through a cultural shift. An example I have noted in my current practice is students highlighting a persistent presence of microaggressions in the workplace despite policies and

unconscious bias training that are supposed to be addressing this issue. While waiting for the system to change, the student may be at risk of developing a victim status and lacks self-efficacy in their professional identity formation. They are also in danger of not progressing through medical school since they are not able to comply with the necessary competencies. The discourse of standardisation therefore locates the problem in the individual who needs to change to match the proscribed rules. The diverse student is encouraged to be resilient and even the more nuanced varieties of this such as flourishing and mindfulness can place the problem in the student as something they need to solve.

This study presents data from the viewpoint of the individual as they interact with the institution. Some students took on individual responsibility for the negative feelings and were using resilience as a means to shut out dissonance and deny their original habitus, changing it to that expected by the medical school. Other students who experienced dissonance expected the institution to manage their negative emotions. Whereas a third group seemed to use resilience pro-actively as a means to deal with the current situation and develop coping strategies often through the medium of impression management.

An approach to resilience that combines both the individual and system aspects has been suggested. In this model, there is an understanding that in addition to developing personal characteristics, students need to be aware of the social and political climate and be reflexive about their own reactions in relation to the social world (Howe *et al.*, 2012; Peters *et al.*, 2018; Zwack & Schweitzer, 2013). These students need to be aware of the effects of the hidden curriculum as mentioned by some of the participants in this study. This combines the approaches of locating the problem in the individual versus the system, by ensuring that a student is aware of the deficiencies of the system. Zwack & Schweitzer (2013) studied medical professionals who had avoided burnout and found that useful protective attitudes included self-awareness and reflexivity, engagement with the downsides of the medical profession and rejection of victimhood. This approach fits with the third

option followed by some students in this study of using social constructivism to manage the challenges to their habitus.

Victim sensitivity

This study suggests that some students were adopting a victim status in response to challenges to their habitus, and that this was not necessarily beneficial for their well-being or progression at medical school. In general terms, a victim is someone who has been harmed, injured or killed as the result of events or actions of others, and the rights of such a person are set out in documents such as *Code of Practice for Victims of Crime* (Ministry of Justice, 2015). However, not everyone who has experienced such adverse events will choose to identify as a victim, and adoption of victim status tends to be a more socially constructed concept (Schmidt *et al.*, 1995).

A tendency to assume a victim mentality in hostile environments is a personality trait known as *victim sensitivity* (Gollwitzer *et al.*, 2015). According to Gollwitzer and others (2015), enhanced victim sensitivity is a learned behaviour in those who have a higher basic need for trusting relationships. As a result of experiences that betray this trust, victim sensitive individuals may become suspicious and withdrawn often ruminating about the perceived injustice. They may blame their misfortune on others and feel powerless to make changes (*ibid.*). Adoption of a victim mentality is often used as a defence mechanism by individuals and can manifest itself in adverse behaviours including uncooperativeness and selfishness (Zitek *et al.*, 2010).

This social theory can be linked to the participants in this project as this personality trait is often formed by experiences in adolescence and early adulthood (Flanagan & Stout, 2010). It is also possible for individuals to have an observed rather than direct experience of victimization and this *vicarious traumatization* may occur for example by witnessing events in the media (Gollwitzer *et al.*, 2015). This may be relevant when considering the increased exposure of the participants to reports of worldwide racial and sexual discrimination in recent years. When considering racism, McWhorter (2003 p. 50) talks about the underachievement of African American

students which he believes is directly caused by the 'victimology, separatism and anti-intellectualism' of African American student adopted as a result of discrimination. This suggests victim sensitivity as another possible cause of the differential attainment discussed above (p.73).

Impression management

The most reflexive students in this study, seemed to be aware of the differing message delivered by the paradigms and hidden curriculum and were actively trying to manage the situation. They were openly using social constructivism and Goffman's performance theories to manage their professional identity. An example here is of the student who was performing as the president of a student society. This involves a dramaturgic representation with a chance to practice backstage performances before committing oneself to a frontstage performance. By carefully controlling the aspects of themselves that were seen by others, individuals were actively managing their presentation through impression management.

As part of impression management, students mentioned the need for variable behaviour in different settings. They spoke about presenting a 'face' or fake persona to manage some of the challenges to their habitus and mentioned incidences where they would practice professionalism in unofficial frontstage or backstage areas such as at student societies or in holiday jobs outside of medicine. They seemed to be aware of the conflicting paradigms being delivered by the hidden curriculum but pragmatically found a way to manage the situation. This would mitigate the dissonance and moral injury they were experiencing whilst conforming enough to comply with medical school rules.

It seems that these students were openly following the so-called 'fake it til you make it' axiom, where their frontstage performances, often by their own admission were not authentic. With so much emphasis on probity in medical education, there is a concern that faking responses and employing impression management may be unprofessional with one result being expression of a *fake empathy* (Stefanello,

2022). Yet some skills need to be rehearsed before the learners are competent and can be performed unsupervised on patients. The important thing is that the students have agency to develop these performances and remain reflexive about what they are trying to achieve. The students in this study were able to express an awareness that this was temporary coping mechanism *en route* to developing their complete professional identity. In this way they were sustaining a critical reflexivity with an agility to adapt to changes in the system.

There is an emphasis in medical training on students developing empathy to help them better relate to the patients and assist in patient-centredness. Although students often demonstrate empathy on arrival at medical school, there is evidence, as seen in this study, that this deteriorates during the clinical years (Hojat *et al.*, 2009; Oliver, 2017; Pedersen, 2010). Clinical empathy can be divided into *affective empathy* or an emotional response to the patient's situation, and *cognitive empathy* or an active attempt to understand the patient's situation from their viewpoint (Stefanello, 2022). Cognitive empathy is what is often taught in clinical training yet from my teaching experience, students dislike having to demonstrate empathy by repeating stock phrases such as 'I understand how you feel' (Laughey *et al.*, 2020). One student in this study mentioned feeling forced to cry to demonstrate reflection. Students preferred to use non-verbal expressions of empathy and when made to use empathic phrases, describe an empathy dissonance that may be one of the reasons for the erosion of empathy (*ibid.* Stefanello, 2020). To counteract the erosion of empathy, some authors have proposed an increased emphasis on affective empathy development (Laughey *et al.*, 2020) encouraging students to adopt values driven, person-centred approaches (Bansal *et al.*, 2021). By accepting their own feelings and emotions they are more likely to be able to move outside the biomedical model and understand what the patient is feeling. This reflexive approach to empathy is more aligned to the reflexive development of resilience mentioned above and can be aligned to impression management.

There is also concern that impression management may close off learning opportunities, as presenting a competent persona can mean an individual will not

ask questions for fear of showing their ignorance (Huffman *et al.*, 2020; Patel *et al.*, 2018). Pretending to have skills that they have not yet acquired could lead to a lack of authenticity which may perpetuate the hierarchies in medicine. However, these particular studies were carried out on populations of qualified doctors whereas medical students are known to be learners without responsibility for patient care. Medical students are expected to demonstrate many key skills through simulation and role-play before practising on a patient (GMC, 2018a; Motola *et al.*, 2013). It seems reasonable that they should be able to rehearse their professionalism skills on both the backstage and frontstage as they move towards developing a medical professional identity. Students should not be criticised for producing unauthentic performances but praised for becoming active participants in constructing their professional identities within the confines of an imperfect system.

The role of the medical educator

This then leads to the question of what we should be doing as medical educators to help students obtain an appropriate medical habitus and negotiate the paradigmatic debate. Widening participation students who lack social and cultural capital and who gain a place at medical school are known to need extra support beyond academic skills (Patterson & Price, 2017). However, there is an unwillingness to single out these WP students once they become part of the student population (Krstić *et al.*, 2021). What is also clear from the intersectionality methodology in this study, is that not all diverse students will have a WP label. BME students whose parents are doctors and who have attended private school, will not be labelled as WP but may still experience discrimination in the field of care giving. Students from a variety of backgrounds may have difficulty utilising capital in the field to develop a medical habitus. Therefore, we need to ensure all students are better prepared for transition into the field of care giving, whilst being aware that the transition process itself provides some impetus for change (Kilminster *et al.*, 2011).

Whilst the students are in the field of education, we need to be more explicit about the realities of the workplace. There is a tendency to gloss over the negative aspects

or present a glib version about the whistleblowing policy and raising concerns without addressing the resultant challenges. One suggestion in the past about how to protect students from the erosion of empathy was to ensure students did not meet the most difficult patients in the first clinical year (Hojat *et al.*, 2009). The opposite is probably true; we need to be more honest about the realities of the workplace and presence of the hidden curriculum and the competing discourses at an early stage in the student education. Students should experience the difficult scenarios in a supported environment where they can discuss any negative emotions. We need to encourage a reflexive version of resilience allowing students to position themselves within the realities of the social world (Howe *et al.*, 2012; Zwack & Schweitzer, 2013). The students will therefore develop a critical reflexivity and become more confident to recognise and deal with the imperfections in the system.

Whilst encouraging students to develop a medical habitus we need to be more understanding about those that are having difficulty to utilise their capital within the field of education and care giving. Medical educators should be more aware that students are rehearsing their professional identities through social constructivism and encourage this with opportunities for role play and simulation particularly around difficult conversations, such as what to do if a patient makes racist remarks.

It is important that medical schools allow sufficient formative experiences for the students to practise their professionalism skills through role-play on the backstage where they still feel empowered to ask questions. An example of this may be the widespread practice of informal near-peer teaching where senior students teach and deliver formative assessments for the junior students (Bowyer & Shaw, 2021). Students often find it easier to ask questions of other students or junior doctors rather than consultants (*ibid.*). We need to provide more opportunities for this near-peer teaching and recognise this has a useful role for students to practise impression management and try out their professional identities. Having discussed the findings of this research and their relevance to the research questions, I continue in the final chapter on conclusions to reflect on my findings, discuss the limitations to this study and to consider future steps.

Chapter 7- Conclusions

This is an educational doctorate designed to take place alongside a professional role in my field of work and inform future practice both for myself and other medical educators. In this final chapter, I summarise the conclusions of this work and discuss the contribution to my professional role and wider professional context including the dissemination of findings and potential publication. Finally, I reflect on the impact of carrying out this study, for me personally and for my future learning.

This thesis is situated in the competing discourses and discusses the impact these have had on all aspects of medical education. As an educator and clinician, I have frequently been made aware of the discourses and the hidden curriculum, but I may have dismissed these issues as difficult individuals or situations, rather than seen them as part of an overarching message. Realising that for example the competition between research and education at University level is part of a discourse makes it easier to comprehend. Knowing that the WP agenda is affected by the discourse of standardisation helps to explain the mixed messages that are being presented. Understanding the intricacies of the situation demonstrates that the solutions are unlikely to be simple but will be multi-layered and complex.

This social constructionist study has used the theories of Bourdieu and Goffman to explore how diverse students negotiate the competing discourses to forge a professional identity at medical school. It has observed their experiences in all settings of their medical education and commented on their expressed dissonance and moral injury. Importantly in an effort to extend the literature on this subject, it has sampled students at more than one institution and used social theory in an attempt to bridge the gap between the discourses. However, the significant additions to this body of work lie in the discussions in how the students are managing the dissonance that they experience.

Students with a habitus that does not match that expected by the institution have several choices. They can use resilience to deny their original habitus and conform

to expectations of the institution but this risks increased moral injury and adverse mental health outcomes. They can maintain their original habitus, expecting the institution to manage the outcomes of their negative experiences but this can lead to an adoption of a victim status and issues with progression at medical school. However, a strategy being employed by the most reflexive students is the use of social constructivism, with a tacit understanding of the competing paradigms to negotiate a professional identity.

I have discussed above the necessity for students to develop a medical habitus and suggest this is the means by which a professional identity becomes embodied. However there remains a question about the extent to which diverse students should be expected to conform with the professional and institutional norms and whether they can retain aspects of their own diverse habitus. Since the competing discourses will have divergent views on this, the deciding factor in practice seems to be that of patient safety. I have seen these decisions enacted in my own workplace where discussions on whether to suspend a student are considered in the light of the impact on patients. However even this argument is open to interpretation, with discourse of standardisation saying competencies must be met to ensure patient safety and the discourse of diversity saying inclusivity and increased tolerance for difference will lead to enhanced patient outcomes.

Since the pace of change in institutional discrimination will be slow, there is an advantage to a method where students can be critically reflexive. They can recognise the gaps in the system and explore the most beneficial ways to forge their emerging professional identities. Medical education should facilitate this ability for students to co-construct their professionalism in relation to their peers and colleagues. Engaging learners in this critical reflexivity will lead to increasing trust in the education system and hopefully ensuing culture changes to an imperfect system.

Impact of this research

I am aware from presenting this work to other educators, that the recommendations from this research may be challenging. Educators based in medical schools tend to sit in the discourse of diversity and from this stance, diverse students should maintain their original habitus while the system changes to accommodate their dissonance. This discourse promotes the enactment of policies such as the Duty of Candour (GMC, 2015), whistleblowing policies and the BMA racial harassment charter (BMA, 2020b) to expedite this process. Expecting students to use agency to manage their own dissonance can be seen to be a failure on the part of the institution. However, in practice changes to the system will always be affected by the discourse of standardisation and progress will be slow.

The alternative view, that students should use resilience to change their habitus and conform to the discourse of standardisation is equally challenging. As discussed above, using resilience to deny one's habitus can lead to burnout and adverse mental health outcomes and I have noted the increased incidence of this in my medical school in recent years.

I am suggesting, as is currently happening in our medical schools, that students employ agency and use social constructivism to negotiate the hidden curriculum and emerging professional identities. By remaining reflexive and being aware of the social framework and messages delivered by the hidden curriculum, the students can pro-actively manage the dissonance they experience and practice solutions through performance management.

As educators, we can encourage this reflexive practice by being more explicit about the presence of the discourses and the hidden curriculum. Rather than discussing resilience we can encourage students to develop tools such as reflection and person-centredness to help them develop more self-awareness. Near-peer teaching can encourage students to use performance management in a safe space, to act out their emerging professional identities.

As medical school leaders we can continue to encourage policies that help to reduce incidences of microaggressions and discrimination for our students, whilst recognising that the students themselves also need to be reflexive and aware of the nature of the difficulties. Widening participation students should be offered more targeted support on entry to medical school, and on other transition points despite the current concern about stigmatising these students. Assuming all students at medical school fit into the same mould, is symbolic violence that denies the habitus of the diverse students.

Future research opportunities

I have discussed some of the limitations in the methodology of this study in the reflections on methodology section on page 110. As a social constructionist study, the findings in this study are not intended to be generalisable but more 'comparable' and 'transferable' (Cohen *et al.*, 2017; Lincoln & Guba, 1985). Validation of the findings by triangulation or methods such as participant checking of transcripts are generally not used in a constructionist study (Guba & Lincoln, 2005). As mentioned above, the rigour in this study is reflexivity on my part as a researcher and the way I have embedded myself in the research to generate a version of the truth. I have examined the data and presented my views around how cultural aspects are affecting the professional identity of medical students. The discussion of these views then 'joins the conversation' around the paradigmatic debate and professional identity formation (Lingard, 2015).

Having analysed the data and considered the social constructivist element of this study I would like to have explored in more depth what the diverse students are doing to manage the challenges to their habitus. I would like any future research I undertake to be based around this third research question 'what do students draw on to manage these negative experiences as they develop a professional identity'? However as mentioned above, negative experiences may need to be reframed as critically intensive learning periods (Kilminster *et al.*, 2011).

Encouraging diversity in a social world where discrimination remains in evidence is a topic of interest generally and in medical education in particular. I have been invited to speak on the subject of this research at an Anti-Racist Practice in Medical Education conference and at a UK teachers of medical professionalism conference. Apart from the useful discipline of formulating my arguments for an audience who are fresh to the topic, I have been genuinely encouraged by the response of the audience to being presented with innovative ideas such as the power of discourses or the hidden curriculum. They are able to see how this applies to issues in their areas of education although some of these ideas such as expecting the student to manage the dissonance due to their own discrimination have been challenging to those in the discourse of diversity. I hope to continue presenting this work and develop my own views through interaction with others as a contribution to this field.

Recommendations

In this study, the most reflexive students seemed to be the ones who were using social constructivism to construct their own professional identities in the light of adverse experiences. I am aware that medical educators may feel that this excludes them from the process and promotion of this is reminiscent of previous efforts to exhort students to be more resilient, with poor results. However, I feel that the social constructivism being employed by the students is more mindful and goal orientated than simple resilience building. There are ways for medical educators to facilitate these efforts and I have some recommendations to allow the educators to enable this process.

1. Make more efforts to support students with vulnerabilities while they are progressing through medical school. These will include students with a WP label at entry and those with protected characteristics that may make them more prone to negative experiences.
2. Be clearer about the realities of discrimination present in the workplace particularly in the field of care giving and discuss some of the discourses that

impact on this, including the hidden curriculum. Explain that although there are policies in place to change these unfavourable practices, students are still likely to experience negative events related to cultural differences.

3. Facilitate the students ability to deal with the negative experiences by providing explicit teaching sessions covering these topics. These will ideally involve role play to allow the students to utilise impression management and practice their responses on the backstage, before being presented with the reality on the frontstage.
4. Introduce more near-peer teaching, particularly in sessions dealing with these experiences. The taught students will gain from first hand accounts of older students and junior doctors who have had similar experiences and feel empowered to ask questions as they experiment with their professional identities on the backstage.

Future steps in my learning

I have moved to a different work role over the course of the eight years I have been pursuing this doctorate and this has reflected my change in focus as I progressed through the modules. Initially I was part of the medical school faculty, with a responsibility for presenting students with professionalism issues to the University Fitness to Practise process. In conversations with students, I was able to hear the challenges about their understanding of professionalism and how they negotiated their professional identity. Although through my reading I could see there was a wide literature base on medical professionalism, the students on the ground remained confused, and worse often transgressed rules that would 'reach the threshold' for referral to student Fitness to Practice (GMC, 2016c). My first module in Foundations of Professionalism was therefore based on trying to unpick the definitions of student professionalism and achieve a better understanding of the concepts underlying medical professionalism. As the Director of Curriculum and Assessment I was tasked

with ensuring all assessments were fair and robust including assessment of professionalism. Therefore, in *Methods of Enquiry and the Institution Focused Study* I moved my attention to assessment and turned to exploration of how the assessors were making these often subjective judgements about students.

Since working on the thesis part of the doctorate, I have become the Dean of an independent medical school, with large numbers of overseas students. I am now more involved with setting the strategy and direction of the school through policies and practice. Despite the high fees, I am keen to see how I can preserve widening participation for all students and ensure the experience of the international students is the same as the home students. I can see that my students are still struggling with the topic of professionalism and want to explore how aspects of culture could impact on medical student professionalism. I can see that students find the move from the early years (field of education) to the clinical years (field of care giving) challenging to negotiate. As a Dean it is my responsibility to explore this transition between different parts of the course and consider how improvements can be made.

As discussed in my reflective statement, pursuing the EdD has been a stimulating journey on my path as an educator and clinician. Researching a topic so closely linked to my area of practice has influenced my relationships with medical students and other educators and ultimately with patients. Understanding how the competing discourses and hidden curriculum affect the decisions made in medical education, has encouraged me to question accepted norms. A recognition of habitus as an embodied disposition has helped me appreciate the diversity of the student population. This has been aided by my move to an independent medical school where although there are common aims to create GMC accredited doctors, we are often following a different path. The EdD has given me a schema to ask the difficult questions and pursue alternative directions and 'make strange' that which is taken for granted (Kuper *et al.*, 2010).

This study has also enhanced my clinical practice as realization of the power of the competing discourses has helped to explain some of the current processes,

hierarchies and discriminations present in the NHS. I found the enduring presence of sexism and racism in clinical practice somewhat surprising and realise that more needs to be done on all sides to influence the culture of medicine and medical education.

I also need to consider my next steps. Going back to my original aims for doing an EdD, I have achieved the senior educator role I was trying to pursue at the start of this doctorate. I have enjoyed demonstrating to the medical students and my younger staff members that this EdD is life-long learning in practice. Despite some fractious times during the process, my love of learning is still intact. However, I am going to need to deal with the end of this long process. I am already aware that I mention my research in almost every conversation, both medical and outside of work. Gill and others (2009) talk about doctorates never being finished but just set aside, and a need to re-join civilisation at some point. I will have to focus on this to avoid becoming overly immersed in one topic. However, I am also keen to publish some of the findings from this thesis and know I need to think about this sooner rather than later before the impetus has moved on. I will be drawing on my excellent supervisors for more advice and guidance in this area.

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Appendix 1: Information sheet



Institute of Education

Information sheet for doctoral research project- EdD – January 2020

Dr Joanne Harris

You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. I am undertaking this study as part of my professional Doctorate in Education (EdD) at the UCL Institute of Education (IoE). I have received no funding for this study.

Study Title

Professional identity formation at medical school: a qualitative study to explore how cultural factors shape professional identity formation of medical undergraduates.

Purposes of the study

The teaching of professionalism at medical school is an important topic but it is not clear whether schools are focussing on developing professional behaviours, (the 'doing' of professionalism) or a professional identity (the 'being' of professionalism). In parallel, medical schools have been asked to increase their cultural diversity to more accurately reflect the population they serve. Consideration has been given to what makes an individual consider medicine as a future career and academic progression through medical school. However, the cultural factors as they relate to professional identity formation throughout medical school have not been addressed. This study is aiming to explore in what ways the cultural identity of a medical student affects the development of their professional persona towards becoming a doctor as they progress through medical school.

Why have I been chosen?

The questionnaire is being distributed widely because I am keen to survey the views of a range of individuals about their thoughts on professional identity formation at medical school. This will include medical students and those who teach students at medical school.

What will I need to do if I take part?

I am distributing this questionnaire to medical students at two UK medical schools. This should take no more than 10 minutes to complete. Following this you may be invited to an interview lasting about twenty minutes which could be conducted by telephone. If you are taking part in the interview you will need to sign a consent form.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a consent form for the interview. If you do decide to take part, you are still free to withdraw up until the point of anonymisation of the data without giving a reason.

How will the interview be conducted?

During the questionnaire you will be able to indicate if you are willing to be approached for a subsequent interview and this will be optional. Participants will be selected for interview from those expressing an interest to ensure a broad spectrum of those interviewed. The interview will last approximately 30 minutes and can be conducted over the telephone if this is more convenient for you. It will aim to cover certain topic areas but you will be free not to answer questions or to raise other points as you choose. The interviews will be recorded with a table-top recorder and I will also make brief notes. They will be transcribed into written form and you will be able to check the transcriptions for accuracy.

Will what I say in the study be kept confidential?

Anything you write in questionnaire or say in the course of the interview will be confidential and will not be attributed to you by name or other identifying information. I would like the ability to use direct quotations both in my work for the doctorate and any published literature although I will ensure that individuals cannot be identified.

What will happen to the data after the study?

All the data in this study is subject to the UCL general research participant privacy guidelines. The data collected from the questionnaires and interviews will be used to contribute to a thesis on professional identity formation that I will submit to the Institute of Education, UCL. will be stored securely in electronic and paper format and only I will have access to the data. All participants will be able to review transcripts of their own interview and the final written research project if required.

Will the study be published?

Although this will be presented as a thesis as part of my EdD, I plan to present this data at education conferences and to publish this study in future. In the event of publication, I will ensure anonymity is fully maintained.

Who has reviewed the study?

The research has been approved by the education ethic process at Institute of Education, UCL and has been reviewed by the ethics department at other involved medical schools.

The controller for this project will be University College London (UCL). The UCL Data Protection Officer provides oversight of UCL activities involving the processing of personal data and can be contacted at data-protection@ucl.ac.uk. This 'local' privacy notice sets out the information that applies to this particular study. Further information on how UCL uses participant information can be found in the 'general' privacy notice. For participants in research studies, click [here](#). The information that is required to be provided to participants under data protection legislation (GDPR and DPA 2018) is provided across both the 'local' and 'general' privacy notices.

Contacts for further information: -

Dr Joanne Harris

EdD doctoral student
UCL Institute of Education (IOE)

Or for further information – **project supervisor**

Dr Sandra Leaton-Gray

Appendix 2 : Consent form



Institute of Education

CONSENT FORM (January 2020)

Study title

Dr Joanne Harris, Institute of Education, UCL

Professional identity formation at medical school: a qualitative study to explore how cultural factors shape professional identity formation of medical undergraduates.

Please Initial Box

1. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw from the study without giving reason up until the anonymisation of the data. I understand that my withdrawal will have no impact on my progression or work in the medical school.

3. I agree to the interview being audio-recorded and the data being analysed for the purposes of the study.

4. I understand that I may review the transcribed data and the final study.

5. I agree to the use of anonymised quotes being used in publication of the study and understand the data will not allow me to be identified in any way.

6. I agree to take part in this study.

Name of researcher-----

Date-----

Signature -----

Name of participant-----

Date-----

Signature -----

Appendix 3: Sample of codes and themes

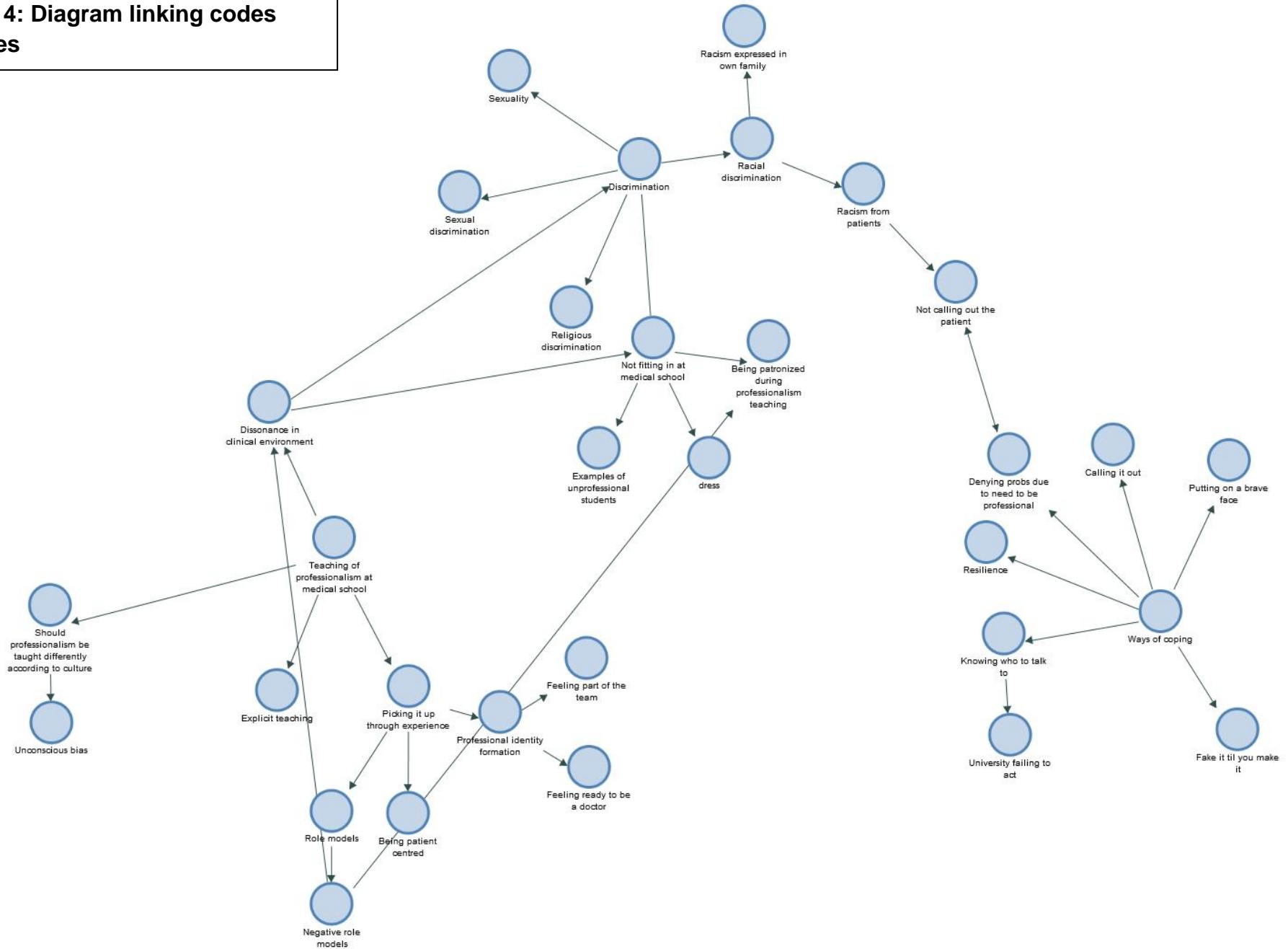
Medical professionalism study – 21/02/21

Name	Description	Files	References
Calling it out	Using impression management to present a professional persona	3	3
Denying probs due to need to be professional	Using resilience to deny their original habitus	1	1
Discrimination	Changing experiences on moving to field of care giving	1	1
Racial discrimination	Challenges to habitus on arrival at medical school	4	8
Racism expressed in own family	Perceptions of fitting in at medical school	1	1
Racism from patients	Changing experiences on moving to field of care giving	5	5
Not calling out the patient	Using resilience to deny their original habitus	3	5
Religious discrimination	Perceptions of fitting in at medical school	2	2
Sexual discrimination	Changing experiences on moving to field of care giving	6	12
Sexuality	Perceptions of fitting in at medical school	1	1
Dissonance in clinical environment	Changing experiences on moving to field of care giving	4	6

Name	Description	Files	References
Knowing who to talk to	Perceptions of fitting in at medical school	1	1
University failing to act	Maintain habitus expecting institution to manage the situation	1	1
Dress	Perceptions of fitting in at medical school	1	1
Examples of unprofessional students	Perceptions of fitting in at medical school	1	2
Fitting in at medical school	Perceptions of fitting in at medical school	4	8
Putting on a brave face	Using impression management to present a professional persona	3	7
Resilience	Using resilience to deny their original habitus	1	2
Should professionalism be taught differently according to culture?	Perceptions of fitting in at medical school	3	3
Being patronised during professionalism teaching	Maintain habitus expecting institution to manage the situation	1	1
Fake it til you make it	Using impression management to present a professional persona	4	6
Feeling part of the team	Perceptions of fitting in at medical school	2	3
Feeling ready to be a doctor	Role models and experiential learning become more important	2	2

Name	Description	Files	References
Picking it up through experience	Role models and experiential learning become more important	2	3
Professional identity formation	Role models and experiential learning become more important	3	4

Appendix 4: Diagram linking codes and themes



Appendix 5: Demographic data of interview participants

		Gender	Age	Yr.	Occupation (of parent)	NS-SEC	Race/ethnicity	Religion	Home /Int	School
Acorn	A1	F	19	2	Secondary school teacher	2	British Pakistani	Muslim	H	State/ Grammar
	A2	F	22	4	Policeman	2	White British	Atheist	H	State
	A3	F	23	4	Mechanical engineer	1	White British	Agnostic	H	Grammar
	A4	F	23	4	Doctor	1	Pakistani	Muslim	H	State
	A5	F	23	4	Unemployed	8	Pakistani	Muslim	H	State/ Grammar
	A6	M	19	2	Doctor	1	British Indian	Hindu	H	Grammar
Beech	B1	M	24	5	Bank teller	3	Afro-Caribbean	Christian	Int	State
	B2	F	24	5	Lawyer	1	White British	Christian	H	Private/ State
	B3	F	19	2	Computer programmer	3	British Indian	Hindu	H	State
	B4	M	23	5	Engineer	1	British Bangladeshi	Hindu	H	Grammar
	B5	M	22	5	College lecturer	2	Asian other (Korean)	Christian	H	Grammar
	B6	F	22	5	IT consultant	1	Asian other (Sikh)	Sikh	H	Grammar