Experience of Transition of Medical Undergraduate Students in the Early Years of Medical Education

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Submitted in accordance with the requirements for the degree of

Doctor of Philosophy

The University of Leeds

Faculty of Medicine and Heath

January 2025

The candidate confirms that the work submitted is his own and that appropriate credit has been given where reference has been made to the work of others.

Acknowledgments

I would like to thank the participants of this study who generously gave time to share their experiences during their first two years of transition in medical school. My transition through the doctorate has been extensive and intensive at times, but enjoyable. I hope to have brought a contribution to the field of medical education by recognising underrepresented learners and the contribution which they can make not only to the important work in medicine, but also to the potential development of medical education.

In addition, my gratitude extends to Professor Anne-Marie Reid and Dr Valerie Farnsworth who have given me outstanding and continual support throughout, guidance which has been both engaging and enjoyable. The doctoral journey has been enhanced by their encouragement for me to share my work at national and international medical education conferences and with other doctoral students in the faculty.

The institute of medical education at the university, being extremely supportive of PGRs through the provision of developmental activities, has made a considerable contribution to my doctoral transition. In this respect, I must extend my gratitude to Dr Rebecca O'Rourke, Dr Alison Ledger, and Dr Naomi Quinton for their continual support on many levels.

I cannot end these acknowledgements without recognising the person who provided the initial trigger for me to commence the doctorate. Dr Mario Torres-Brown, originally a surgeon in the UK, had flown from his home in Columbia to celebrate the graduation of his son in Madrid. Spending a few days in London before the flight home, his son (a friend of my daughter) had arranged a lunch as an opportunity for us to meet. During the conversation through the meal, he mentioned he had just completed his PhD, with me commenting that I was too old to pursue that route. His response was, "No you are not, I am 80-years old, and I have just done one." That was the spark, a turning point for me to reflect and curate a proposal for research in medical education.

This thesis is dedicated to my daughter Lauren Elizabeth Hargreaves

Lauren, I want you to know that I could not have completed this doctorate without your motivational support, especially with your considerable information technology ability, and the encouragement during the final intense period of authoring the thesis. I cannot thank you enough!

Abstract

Experience of Transition of Medical Undergraduate Students in the Early Years of Medical Education.

Focusing on the progressive increases in the admission of medical students from widening participation backgrounds, specifically those who are from first in family to access university, the study captures unique experiences during the early years of medical education at a research-intensive university. The study contributes to the theorisation of transition and considers how these hitherto underrepresented students might be effectively supported.

The purpose of exploring the personal transitional experience of first in family medical students was three-fold. Firstly, recognising continuous increases in this demographic, and secondly, challenging previous research deploying deficit models (O'Beirne et al., 2020; Curtis et al., 2021). Deficit models suggesting that students lack social and cultural capitals (Bourdieu, 1973) which impact on their preparedness for success in higher education. Thirdly, the need to develop theoretical explanations of transition which recognise the personal lived experiences of first in family students to access medical education. The existential methodology recognises transition as a phenomenon, with longitudinal semi-structured interviews exploring ongoing changes in learning and identity through a form of reflective dialogue.

Findings of the study over two years reveal stories of transition in first in family students, which demonstrate higher levels of social and academic preparedness for higher education than some earlier studies examining inequities in access suggest. Increased agency in students, through reflection and narration of their own story of transition, has potential to create a sense of a transformative self. Recognising students' individual subjectivities, as a means of them owning the contextual situations in which they learn and 'become doctors', could additionally work towards increasing positive self-esteem and wellbeing.

A more nuanced conception of transition as a plural construct, which contests previous socio-structural models, might invoke new inclusive educational practices for the benefit of more socially diverse students. Transition is more usefully envisaged as a uniquely, personal life-transforming concept, rather than socio-structural definitions between levels of education or specifically defined stages of change. An internal locus of control is pertinent for students (Bean and Eaton, 2001) being provided through opportunities to reflect, increase agency, and internalise personal adaptations to learning and the transitional process itself.

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Definition of Terms

Aspirational Capital: 'The hopes and dreams' students and their families have despite persistent education inequities (Yosso, 2005).

Becoming: The student's perceived changes in identity and personal adjustments made on entry to medical school and the subsequent years.

Being in the world: Learning to be self in society and experiencing it (Jarvis, 2006).

BMA: British Medical Association – professional association for doctors in the UK.

Contextualised Admissions: A contextual approach to admissions involves the reduction of academic entry requirements for disadvantaged learners (Boliver et al., 2019).

Cultural Capital: A private resource of knowing, potentially converted into economic capital (Bourdieu, 2005).

EDI: Strategies to increase Equality, Diversity and Inclusion (relevant within the context of social justice and social mobility).

Experience: Meant in two different ways (1) a direct encounter with the external world, and (2) a socially constructed, mediated experience we commit to memory (Jarvis, 2006).

Familial Capital: Personal human resources, drawn from their extended familial and community networks which students can leverage into positive experiences in further education (Yosso, 2005).

Field: Objective structural relations within a social space, constructed by individual subjectivities; a field of knowledge. E.g. home/community / secondary education field, the HE / medical school field (Bourdieu, 2005).

FiF: First in Family - This refers to a student whose parents or guardians do not have any experience of higher education (The Office for Students, 2024).

Habitus: Attitudes and dispositions which are structured by family, community, and educational experiences. There may be a distinction between habitus transmitted in the home and a more dominant habitus in society at large, which has a positive attitude towards education (Bourdieu, 1985).

HE: Higher Education – Tertiary education leading to the award of an academic degree.

HEI: Higher Education Institute – A specific university or other body providing degree courses.

Imposter Syndrome – is described as a feeling of inadequacy that persists despite evidence of success (The British Medical Association, 2024).

Life-World: The social world of the student which is 'taken for granted' until some experiential disjuncture creates dissonance which requires resolution and a new meaning (Jarvis, 2006).

Linguistic Capital: various language and communication skills students bring with them to their education environment (Yosso, 2005).

MSC: Medical Schools Council – Organisation representing 48 medical schools in the UK.

Navigational Capital: Students' skills and abilities to navigate 'social institutions', including educational spaces which may be unsupportive or hostile environments (Yosso, 2005).

Person-in-the-World: Individual is responsive to the world and sources of activity in it (Jarvis, 2006).

Resistance Capital: Founded in situations of disadvantage and legacies of engaging in social justice (Yosso, 2005).

Russell Group: Association of 24 public universities with shared focus on research and academic achievement (linked to status in the HE marketplace).

SES: Socio-economic status - The combined economic and social position of an individual or family in relation to others.

Social Capital: Who we know within a network of established relationships, which can provide advantageous transitions and openings to increased cultural capital (Bourdieu, 2005) e.g. healthcare professionals. Yosso (2005) defines the network as 'peers and other social contacts … which students utilise to gain access to further education and navigate other social institutions.

SoM: School of Medicine – Faculty within a university for the study of medical education and practice.

Transition: Personal learning trajectory of a learner, as perceived by the individual (Jarvis, 2006).

WA: Widening Access – A government initiative offering opportunities to groups of underrepresented people, in this context initiatives in medical education (Ojha and Patel, 2017).

WP: Widening Participation – giving opportunity to anyone who has the ability and desire to enter a medical career (The British Medical Association, 2023).

1. INTRODUCTION

The aim of this study is to focus on the transitional experiences of students who are first in family (FiF) to access medical education at a Russell Group University. Within this introduction, I wish to overview the historical and current situation of the environmental context for the study, followed by my approach to the methodological design, introducing unique elements to investigate the phenomenon of student transitions, and additionally my positionality and justification for the chosen approach.

Historically, most medical students have been from advantaged backgrounds, those with family members in professional careers, including medicine. Essentially this has been the 'traditional' familial route into the medical profession (The British Medical Association, 2009; Bassett et al., 2018). These familial relationships have afforded vicarious understanding and experience of studying in higher education and possibly medicine, representing an intergenerational process outlined in Bourdieu's socio-structural theory (Bourdieu, 1973).

Against this background, there has been an evolution of contemporary admissions practices in the UK employing widening participation (WP) initiatives to democratise entry to medical education and the profession (Hubble and Connell-Smith, 2018). WP addresses underrepresentation in higher education through schemes which attempt to remove barriers to increase diversity and improve access to this previously exclusive career route.

Such practices amongst these schemes include contextualised admissions, processes which allow a slightly lower entry requirement for candidates who meet the criteria for WP. Secondly, the provision of gateway or pre-entry foundation courses. These courses are designed to enable WP candidates to develop study skills and fill gaps in their qualifications prior to entering undergraduate medicine. These interventions have had some success in the context of improving inclusivity and extending the diversity of medical students in the UK and other nations, where social justice and WP to increase inclusivity, has been a political imperative. Examples of this to improve social justice and the status quo in the UK between the years 2015-2020, indicate that increases in medical student diversity were:

1. 58% Students of black heritage
2. 46% Students from the lowest Index of Multiple Deprivation
3. 33% Students with Disabilities

4. 14% Students from State Schools, and
5. 11% Students whose parents do not have HE qualifications

(Medical Schools Council, 2020)

Realising that the data does not provide us with a complete picture of diversity within medical schools, there are two aspects of the data I which I draw specific attention to. Firstly, that it does not account for intersubjectivities across the categories and thereby ignores the potential ideographic representation of individual students. Secondly is that the lowest increase in diversity is for medical students having parents who have not successfully progressed through higher education. Inspired by these indications, I was encouraged to consider how the proposed study might close the gap in our understanding of FiF medical students' transitional process to, and through the first two years of the undergraduate programme in medicine, and additionally, if there are possibilities of intersubjectivity in the participant profile. A discussion of the context and the impetus for the study is provided in Chapter 2.

In parallel to this democratising movement have been research studies in the UK and internationally, suggesting reasons why students from less advantaged backgrounds are seemingly not prepared, or do not wish to access HE. The assumed deficiencies of underrepresented students in respect of lack of knowledge, and skills tends to be a prominent discourse in the research, with Bourdieu's theory often used to ground the argument. It is believed that this 'deficit discourse', or deficit model, should be challenged in medical schools (Curtis et al., 2021). The deficit model generally, tends to risk the pathologising of these underrepresented or minoritised students (Nicholson and Cleland, 2017), and therefore demonstrating, and possibly promoting, a level of institutional exclusivity.

Themes assuming a deficit perspective of underrepresented students, followed by an assets-based perspective are usefully explored in Chapter 3, relevant research literature exploring the transitional process. The uniqueness of my approach is one attempting to explore and theorise the personal nature of individual transitions, experienced by FiF students.

I present a collated range of theories and theoretical concepts in Chapter 4, as a consideration of ideas useful in constructing a conceptual framework. I employ the term 'bricolage' to describe my approach to integrate the theories, and secondly to situate each student as a potential 'bricoleur' in the context of their reflections and considerations of their perceived transformations over time. In French culture, the term bricoleur refers to a handyman who undertakes minor repairs and improvises technical solutions with existing materials. Levi-Strauss (1962) applies the image to

thought, which re-uses available material to solve new problems. The conceptual framework in Chapter 4 is effectively a landscape of potential 'tools' for exploring personal transitions of FiF students. The theoretical framework and conceptual tools employed, sensitised and informed me in approaching the medical students' transitional process. The frameworks relate to an understanding of transition as a social process of development. This allows for a breadth of theories which take account of the reciprocal relationship between the person and their social context, rather than narrower constructs which are more concerned with individual psychology.

Fundamental to my incentive to pursue this line of inquiry is my own biography which, in part, could resonate with some underrepresented cohorts of students. My socio-cultural roots from a low socio-economic status (SES) background, living in a predominantly working-class area, and eventually having an extensive career in teaching learners from underrepresented ethnic and working-class backgrounds, opened my interest in exploring this phenomenon.

Consideration of my positionality and required reflexivity in this qualitative research is discussed in further detail in Chapter 5, for me to be cognisant of my interpretation of the narrative data. How undergraduate FiF students make sense of their own personal journey to medical education, and how they perceive any changes in themselves and their identity as they progress through the early years of the undergraduate programme. are provided in the findings from the study in Chapters 6 and 7.

In the Discussion, Chapter 8, I consider the uniqueness of my approach to addressing the gap in the understanding and theorisation of transition, and the implications for bridging this gap within Chapter 9.

2. CONTEXT

> "Britain has a history of division based on social status and class that strongly persists today. It is this stratification that lies at the root of many of the divides we now see so prominently. Social mobility, the opportunity for people to succeed in life regardless of their background, is both low and showing little sign of improvement" (The Sutton Trust and Social Mobility Commission, 2019, p.10).

Introduction

The Sutton Trust and Social Mobility Commission (2019) in over two decades, has pioneered research into the educational backgrounds of those at the top of British society with the organisation purporting that the British education system is partly responsible for the division of privilege. In relation to the inequitable distribution of power and privilege in the UK, and access to elite professions, there is a substantially higher proportion of individuals from privileged backgrounds, occupying the country's elite professions. Laurison and Friedman (2019) indicate that individuals from professional and managerial backgrounds are consistently overrepresented in these high SES roles, the highest which being medicine. This has implications for widening access to medicine and recruiting a diverse population of students. This chapter outlines several factors which contextualise the socio-political and educational landscape of this study, all of which are crucial to effecting a change to ensure widening access (WA) and successful participation in medical training and potentially diversifying the healthcare workforce to improve the service.

Elitism and transcending privilege: The professions

In a UK Policy context, it has been stated that medicine has a long way to go in respect of making access more equitable, diversifying its workforce and raising social mobility (Milburn, 2012; Medical Schools Council, 2016). The literature supports the historic inequality of entry to university to pursue an elite career. Access to higher education (HE) was undoubtedly elitist, particularly in regard to the professions, and more specifically medicine and law, with Thiele et al. (2017a, p.1) emphasising, "pervasive inequalities in participation in HE are greatest in selective and oversubscribed programmes such as medicine". In the past, most students studying medicine have tended to be from advantaged backgrounds, affluent families with members occupying professional careers, including medicine (The British Medical Association, 2009; Kumwenda et al., 2017). Consequently, there has been an imperative to address the issue of low rates of social mobility in the UK, and other countries around the world generally.

Widening access (WA) for disadvantaged, or less privileged groups in society, is a global agenda (O'Beirne et al., 2020). However, the form elitism takes and the impact on underrepresented groups are contextually manifest in different ways in different societies, possibly based on class, gender or ethnicity, or possibly in some instances, intersectional combinations of more than one single classification. In Australia for example, WA is usually associated with Indigenous and rural populations. Whereas, in South Africa (Sikakana, 2010) and the United States (Tett et al., 2017), specific ethnic minorities are underrepresented. However, the socio-political issue remains the same across all nations, a precedent for social justice, power relationships, and solutions to initiate change. In terms of exemplar strategies to address the issue of under-representation and provide opportunities for life-changing experiences, the Australian Government announced its commitment to "boost the number of university students from regional poor and indigenous backgrounds" (Duffy, 2023). The policy aims to offer HE places to Australia's 'first people' at any university in the country, to address a considerable under-representation of this specific group. In the UK, Governmental policies, and directives to HE institutions to effect change have been underway for some time where the underlying problem is often framed as both family background and secondary school provision. WP is the term used to describe the strategic response to support underrepresented groups in recruitment became a common feature of higher education institutions. An improvement in recruitment has been an outcome of policy initiatives, though I feel it is not clear whether the HE sector completely understands the problem before solutions are found. Indeed, if we consider the apportionment of 'blame' and use of the word 'problem', perhaps we should think more widely about the distribution of power and wealth. This study not only focuses on fair access to medical education but also the personal experiences of students transitioning the medical education provision.

Social mobility

Social mobility might be defined as 'people succeeding in life despite their family background The Sutton Trust and Social Mobility Commission (2019). Where FiF have demonstrated upward social mobility, they have concurrently transcended the traditional intergenerational process suggested in Bourdieu's socio-structural theory (1973). One notable indicator of success in social mobility might be the increase in FiF students to attend higher education, recognising that students whose parents or close family members have accessed higher education are more likely to aspire to this and gain a place themselves. FiF refers to a student whose parents or guardians do not have experience of higher education and is one of the criteria for 'contextual admission', giving such students grade offers for medicine below the standard required (The Office for Students, 2024).

The Social Mobility Commission (2017) produced a report, 'Time for Change: An Assessment of Government Policies on Social Mobility 1997-2017', indicates that over the two decades, the spending on increasing access had doubled from £400 million to £800 million. The Office for Fair Access (OFFA) (2017) set up in 2004, outlined clear plans for universities to produce clear access plans for recruiting under-represented or disadvantaged students. Though the investment increased recruitment substantially overall, it did not improve retention nor match investment to improve teaching, guidance, and pastoral care, for underrepresented students (Milburn, 2012). Such investment in further provision, it might be argued, could have provided relevant support for learners transitioning through higher education once they had accessed the institutions.

Social justice and benefits of an increased workforce diversity in healthcare provision

Increasing social mobility for under-represented medical students is deemed wholly appropriate and necessary for two principal reasons, firstly, social justice and secondly, improving the healthcare provision in particular geographical locations. Policies to address these issues (social justice and workforce provision) include attracting and training a broader cultural diversity of doctors to service a wider diversity of patients in the local population in which they will work (Medical Schools Council, 2016). The principles of 'social justice', 'access to resources', 'equity', 'participation', 'diversity', and 'human rights' can be seen to apply equally to students wishing to access medical education and to the recipients of healthcare. The British Medical Association (2009, p.8) indicates "doctors should be as representative as possible of the society served in order to provide the best possible care of the UK population". Although reviewing policies and research findings within the UK are essential to mapping out the way forward for this study, I believe it is also useful to consider indications of advancements in other nations.

There have been efforts to address the recruitment of under-represented groups of medical students and concurrently improve the diversity of the healthcare workforce in other countries. In the case of Canada, under-representation of medical students from rural areas, is mis-matched with the pressing need to produce more doctors to work in the underserved rural areas. It has been indicated that despite 42% of the population in Canada living in rural areas, only 13.4% of Canada's doctors practice rurally (Whalen et al., 2016). Actively targeting students from diverse backgrounds to eventually provide primary care for under-served populations is a marketing strategy in some Australian medical schools. Indeed, many elite schools of medicine offer financial support for students less able to self-fund (Hays, 2020). A positive outcome for the University of Western Australia, having encouraged

indigenous students to study medicine, is that many have subsequently decided to practise in underserved locations once they have qualified, 49 indigenous doctors have graduated since 1988 as part of the efforts to improve the health of Aboriginal people (Collard, 2019). However, in terms of the cohort of graduating doctors in 2019 in Australia, the representation of indigenous graduates was 2.4% of total qualifying doctors, in relation to a 3.8% total population of Aboriginal people in the country (Australian Institute of Health and Welfare, 2024). Nonetheless changing cultural expectations and attracting a more diversified population to the medical profession is perhaps a gradual process that may take time. This indicates the UK is not alone in addressing issues around social justice and gaps in both understandings of the problem and potential solutions are situational. A corollary of this is the international collaboration of research in this field, which is evidenced by some of the studies reviewed in Chapter 3, Review of Literature.

Widening Access initiatives: Increasing representation

There have been a range of initiatives to widen access of under-represented students to medical schools in the UK, often involving 'contextual admissions' which allow social considerations of the individual to be accounted for. This involves acknowledging the individual profile of each student, along with biographical information about socio-economic status of locality, attainment of school attended and relative level of parental education (see Table 1. below). Each university has its own Access and Participation Plan (APP) underpinning an Access Scheme, which grant a reduced grade offer for the specific degree programme which has been targeted by the prospective student. Boliver et al. (2019) remark that a contextualised approach to admissions represents a crucial means of achieving fairer as well as wider access. The eligibility criteria for these schemes may differ between the institutions, though the eligibility criteria in the table below offers a typical menu, where the applicant must meet two or more of the criteria.

	Criteria:
1	Parents did not access higher education - first generation applicant (FiF)
2	Home postcode in an area with low level of participation in higher education
3	From a household with a gross annual income of £25,000 or less
4	Attended a school achieving below national average at GCSE level. Attainment score 8
5	Studies were disrupted due to personal circumstances
6	Living in Local Authority care or have spent time in care

Table 1. Typical eligibility criteria for contextualised admission (UCAS, 2024).

Considerations for the representations of equity, diversity, and levels of inclusion may change contemporaneously and by geographical location. In a particular location, served by an HE institution, there may be recognition of other specific underrepresented groups which potentially require access. A more recent eligibility criterion added to the matrix, by some universities offering an Access route, is being a member of the Gypsy, Traveller, Roma, Showman, or Boater (GTRSB) community. Some access programmes often include supplemental study periods which can promote academic development.

Beyond the eligibility criteria for accessing higher education, initiatives by way of programme provision are varied across the UK. The provision of gateway, or foundation programmes which prepare students for a medical career, might be a stand-alone introduction to medicine course or part of an integrated 6-year programme, where the gateway component is classified as Year 0.

Although there are a number of these WP initiatives, some examples are,

- Access to Medicine, a scheme for mature students, those aged 19 or over, at the Sussex Downs Adult College. The intensive science-based one-year full time course specifically tailored to the requirements of a medical degree.
- The BM6 Programme offered by the University of Southampton where students, completing the Year 0 programme transition to Year 1 of the BMBS undergraduate programme (Curtis et al., 2014).
- In the School of Medicine where this research has been undertaken, the 'Gateway to Medicine' programme, has run successfully since 2021.

Support for applying to medicine

Yet another supportive way of promoting widening access and increasing social mobility in the context of medicine is through the registered charity In2MedSchool (2024) which provides support and free 1:1 mentorship, for 16–18-year-old students, interested in applying to medical schools. The charity is administered and supported by existing medical students or recently qualified doctors, who act as mentors or ambassadors to guide prospective students with knowledge of the medical field and applying for admission. Universities may also offer similar support, possibly peer support by students who are advanced in their undergraduate programme.

Context of the research site

The university where this research has taken place offers a Gateway to Medicine programme, where potential students might progress to a variety of undergraduate programmes, including medicine. The scheme runs from mid-September to mid-July and guarantees special consideration for applicants whose personal circumstances affect an ability to demonstrate talent and potential by grades alone. The applicant receives an Access offer which is two A level grades below the standard offer. However, this scheme may differ from offerings in other universities around the UK. All access programmes and other WA schemes involve the use of contextual admissions, (outlined on the previous page) and in the case of this university, there are several additional routes which can lead to the undergraduate Medicine programme, including the Gateway to Medicine programme, previously mentioned.

The table below indicates that the proportion of WP students, accessing the school of medicine through a variety of access options and the contextualised approach, has progressively increased over time. However, the exception is the decline in the WP profile in 2022-23 due to the period of Covid-19 restrictions, during which Teacher Assessed Grades in secondary schools and university online interviewing seemingly impacted on the access of WP students.

WP Student Intake	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
% of Total Intake	21	26	27	28	31	32	34	36	22	23

Table 2. School of Medicine increases in WP representation 2014 – 2023.

Conclusion

Whilst we may be aware of incremental increases in social mobility, indicated by the proportion of widening access to medical education population, we have not necessarily captured the specific personal impact of the transitional experience for these widening participation medical students, a relative gap in our understanding. To gain a fuller picture of extant research in the field of widening access to the medical education and experiences of students transitioning through medicine, the following chapter turns to a review of literature to establish what has been previously written on the topic (Paré et al., 2015).

3. REVIEW OF LITERATURE

Introduction: Choosing an appropriate literature review methodology

There are several types of literature review methodologies, and within the positivist tradition and assumption that a single absolute truth can be determined through scientific experimentation, 'systematic reviews' might be used to find the best available evidence, on which clinical interventions might be based (Maggio et al., 2022). Examples of studies in medical education using this methodology could be investigating the accuracy of assessment tools or the incidence of burnout in junior doctors (Maggio et al., 2022). However, this type of methodology is only feasible if there is a significant body of evidence to review, and researchers have considerable time and effort to devote to the search. Additionally, systematic reviews are not appropriate where the proposed inquiry is based on a very focussed population, like the one proposed. I have therefore discounted the use of a systematic review methodology to explore underrepresented students in medical education and considered narrative and scoping reviews as possible alternatives.

Scoping reviews are within a qualitative tradition of research, aligning with constructivist and interpretivist paradigms, employing a methodology which casts a 'wide net' to capture a broad overview of emerging knowledge of a specific topic. This permits the capacity of a broader collection and synthesis of literature, including grey literature (Mak and Aliki, 2022, p.561). However, the method is similar to systematic methodology in being very resource intensive (Mak and Aliki, 2022, p.562) in requiring a research team and due to the likely differing perspectives of the team, members need time for reflection and collaborative decision-making (Mak and Aliki, 2022, p.563). As a single researcher pursuing this inquiry, and a reflective practitioner who will be engaged in reflexivity throughout the process, I was drawn to a narrative review, as an alternative.

I have chosen to employ a 'narrative review' methodology, to provide a critical narrative synthesis of literature to bring an interpretative lens to the study, which is shaped by theory (Sukhera, 2022b). My justification for this approach is two-fold, firstly to link my approach to a reflexive account of an educational problem - the transition of medical students who are FiF to access HE Secondly, to validate the chosen methodology in providing a quality review of existing literature, as a sound direction for future knowledge development (Kirkevold, 1997). Unlike other review methodologies, mentioned above, narrative reviews create a reflective account of research in a particular area of interest (Paré et al., 2015). The reflexive nature of this specific review methodology is to consider

ontologically the potential multiple views of reality within the literature reviewed, both authors and potentially the worldviews of participants within the inquiry. An overview of the knowledge claims in the evidence proffered, will be of particular interest, as a broad base to position the development of my study.

Flexibility, rigour, and practicality of narrative reviews

As suggested by Sukhera (2022b, pp.414-415), authors should provide:

Markers of Rigour	
1.	Clear rationale, research question, and target audience
2.	Clear boundaries, scope, and definitions
3.	Inclusion / exclusion criteria / time frame and study design
4.	Reflexivity / author's interpretation and analysis
5.	Justification for type of approach

Table 3. Five criteria for enhancing quality assurance in narrative reviews (Sukhera, 2022b).

My responses in support of the rigour of this narrative review are as follows:

1. Rationale, research question and target audience.

a) The rationale and justification for this review stems from the social justice and increasing social mobility directives, referred to in the previous chapter, to widen access for underrepresented students in higher education, and specifically for this study, access to medical education.

b) The principal research question is: 'How do students, from first-in-family backgrounds, experience transition through medical education in the early years?'

c) The target audience is curriculum leaders and student support services in schools of medicine, researchers, and tutors in medical education.

2. Boundaries, scope, and definitions.

a) The scope and boundaries of the review are centred around widening participation students, who are also first in their family to access HE. Given the relatively limited area of investigation in this field currently, the scope of sampling may go beyond UK examples, to capture the breadth of similar work in the field internationally.

b) Additionally, a range of constructs around transition and identity will need clear consideration of meanings. This is particularly pertinent in my quest to be sensitised to theoretical frameworks and specific concepts, to explore the phenomenon of transition, as mentioned in Chapter 1.

3. Time frame, study design, and inclusion/exclusion criteria.

a) The time frame for research articles is the previous 30 years, and for seminal books, circa 60 years [very few articles or books were at the higher point of the time frame].

b) the study design is qualitative, interpretive, and phenomenological to explore students' worldviews.

c) Sukhera (2022b, p.414) remarks that "narrative reviews do not typically involve strict predetermined inclusion or exclusion criteria" and through the reflexive approach, there may be modification to direction as novel findings are revealed as the literature review evolves. However, the initial search process used the PubMed/National Institutes of Health database, to explore extant articles in the field. The relevant search terms indicated in the table below, were drawn from initial reading, attendance at conferences, and local WP initiatives, for the purpose of raising awareness of increasing social mobility for underrepresented students in HE and medicine especially. The search terms selected are WP, WA, working-class students, and students who are the first in their family to progress to higher education.

Item	Search terms	Articles found	Irrelevant or duplicates removed after first evaluation
1.	Transition of student learning AND medical degree	181	151
2.	Widening participation AND medical degree	56	37
3.	Widening student access AND medical degree	18	12
4.	Working-class students AND medical education	12	3
5.	Working-class students AND UK medical education	5	0
6.	First in family students AND medical education	6	0
7.	First in family students AND UK medical education	2	0
8.	Hand searching (articles added)	111	12 (excluded)

Table 4. Search for relevant literature.

Reasons for excluding articles:

Item 1. The articles excluded were transition from medical student to junior doctor, stress and burnout, pre-clinical to clinical phase, other healthcare associated professions (e.g. nursing, pharmacy, dentist).

Item 2. Majority of articles excluded were clinical / medical science topics, veterinary science, foundation year transition, building medical workforce in international countries, student-led conferences or access schemes generally.

Item 3. Majority of articles excluded were clinical topics, or access to specific treatments.

Item 4. Example of articles excluded were clinical topics, e.g. blood donation and working-class, occupational therapy interventions, or sex education and working-class girls. The title of one article, 'Action Research to explore elitism in medical education' initially seemed relevant, but following an evaluation, was mostly irrelevant.

Item 5. Adding 'UK' into the search term immediately filtered down to relevant articles. Which similarly worked operationally with Items 6 and 7 in Table 4.

Notes:

1. Some additional articles (contained within item 8) were noted from reference lists in the primary source material previously searched, read and then subsequently consigned to either inclusion or exclusion.
2. The total number of papers read and selected for the review was 24 out of a total of 154
3. To provide an indication of the breadth of reading and the nuances in existing research of transition into medical education and transitional experiences during early years of the undergraduate programme, the following table (Table 5) outlines the number of papers in both the UK (96 papers) and international contexts (58 papers); where specific topics have been explored within the field of this study. These crucial topics are aspects of the transitional process (both the learning and transformational experiences of individuals, and additionally methodological elements for illuminating the phenomenon under study.

Research Topic	**UK Context**	**International Context**	**Total No.**
Agency	2	9	11
Assets / Capitals	2	2	4
Bildung and Transformation	1	1	2
Bricolage	2		2
Contextual Admissions	5		5
Doxa / Challenge Bourdieu	3		3
Feedback (Power of.)		1	1
First in Family (FiF)	2	6	8
Impact of Covid -19	1	1	2
Identity	16	9	25
Imposter Syndrome	2	1	3

Learning	2	5	7
Critical Self-reflection	2		2
Narrative Analysis		4	4
Private Schooling	1		1
Professional Identity	2	1	3
Qualitative Research	4	4	8
Self-Efficacy in Education	1		1
Social Mobility	5		5
Transition	24	6	30
Widening Participation / Widening Access	17	6	23
WP Doctor Successes	2	2	4
Cumulative Totals	96	58	154

Table 5. Range and frequency of articles in topic areas in the UK and international contexts

4. Author reflexivity, interpretation, and analysis.

In terms of reflexivity, my perspective and experiences will be explicit to inform decisions about analysis and interpretations. I acknowledge that although I will be transparent about my thoughts and execution of the review, (Sukhera, 2022b, p.415) has suggested that "other authors with the same selection of literature, are likely to produce different insights and interpretations". However, I do not perceive this as a problem because working within constructivist and interpretivist paradigms, it is highly likely that other researchers viewing the same landscape and using a similar 'palette of colours' may, through an ideographic interpretation, produce a different piece of work. The outline of my initial thinking around interrogating potential literature is expressed by the parameters of the search terms in Table 4 above.

5. Justification for a narrative approach.

Despite Sukhera (2022a) remarking that narrative reviews often include a noncomprehensive and non-exhaustive sample of literature on a given topic, my belief is that for the purpose of this review, given my applied criticality and reflexivity within the study, the methodology is sufficiently flexible, rigorous, and practical for the under-researched area to be explored. Critiquing the strengths and limitations outlined in selected studies through a rigorous process will seek any gaps in my chosen field of study, and provide potential directions for the proposed research, and possibly future research within the field over time. Paré et al. (2015) suggests the review of literature process tends

to be: (a) what has been previously written on the topic, (b) finding the extent to which research reveals any trends or patterns in the data (c) aggregating findings related to a narrow research question to support evidence-based practice, (d) generating new frameworks and /or theories, and (e) identifying topics or questions which require further investigation. Greenhalgh et al. (2018, p.2) consider narrative reviews "provide interpretation and critique; their key contribution is deepening understanding" for explorations, "that require clarification and insight (for which a more interpretive and discursive synthesis of existing literature is needed)". Specifically, Boell and Cecez-Kecmanovic (2010) advance the use of a hermeneutic review which capitalises on a continually deepening insight by critical reflection on specific aspects of a dataset, in this case a set of individual primary studies in the field. Equally, in respect of the philosophy and methodology of the data collection and analysis explored in Chapter 5, the hermeneutical approach similarly focuses on the interpretation that student narratives suggest of their lifeworld and lived experiences.

Structure of the review

From my initial reading of the literature, it became clear that the focus on WP students embarking on medical education had developed from that of a 'deficit perspective' to one of a more 'asset-based perspective'. Considering the literature on each of these perspectives in turn seemed a logical way to structure the literature review which took account of transition as a personal, subjective process.

From the literature, three themes have emerged and are worthy of consideration, namely:

Theme 1. 'Literature on WP access assuming a deficit perspective'.

Theme 2. 'Literature on WP access assuming an asset perspective'.

Theme 3. 'WP access to HE as a transitional process for exploring subjective lived experiences of medical education.'

In addition to these forms of literature interrogation, I need to acknowledge that there may be elements of overlap between some constructs within the literature, partly teased out within the Definition of Terms section or in the body of the text. Some examples could be:

1. Widening participation [WP] and widening access [WA].
2. Transition and identity, possibly by means of a disjuncture in thought and emotion.
3. Self-efficacy beliefs and identity.

Whilst these overlapping themes and constructs may appear to be less discrete, they may function to focus on a broad range of intersecting research findings, there might be opportunities to forge potential links with identity transformations, and a more detailed understanding of an internal and personal transitional process, through analysis of students' narratives and worldviews. Indeed, although medical students may not be consciously aware of theoretical constructs employed in educational research, it might well be that there are several touch points where some constructs interconnect and coalesce to explain substantive aspects of an internal transition. These could be potential elements of the students' ongoing worldviews and lived experiences, and how they transition towards becoming a doctor.

Theme 1: Review of literature which may assume a 'deficit- based' perspective

Various elements of Bourdieu's theoretical framework have often been used to explain why some underprivileged individuals are underrepresented in HE especially in high status occupations, such as medicine and law. The studies within this theme are collated around an assumption that potential students accessing medical education lack the requisite skills, and on accessing the undergraduate programme, need to be 'topped up'.

Reay et al. (2009) draw on case studies of nine working-class students at an elite Russell Group University in the South of England, by employing Bourdieu's notions of 'habitus' and 'field' to examine the complexities of student identities. Habitus is being defined as the individual's attitudes and dispositions usually structured by family and school, through the process sociologists refer to as socialisation, and field is the social arena in which individuals find themselves operating. In this case, it could be the home secondary school field or the HE field. Essentially, we have the intersection of the individual, subjective sphere and the social, objective domain. In addition, there is the juxtaposition of two fields, with the attitudes and dispositions formed during early life experiences and the assumptions and expectations of the HE field. None of the parents of the nine participant case studies in Reay et al.'s (2009) study had been to university and were employed in a range of manual or service sector occupations. The students had embarked on a 3-year undergraduate programmes, ranging across Law, History, English and Engineering.

The authors remarked that when the habitus of the individual encounters a field which is unfamiliar, the disjuncture which ensues can generate change and transformations, but also potentially, uncertainty and insecurity. For students from working-class backgrounds, dilemmas may emerge which test their ability to maintain connections with social background, family and friends from the

wider community. Reay et al. (2009, p.1107) commented that “resilience and coping with adversity were qualities more associated with working class than middle classness”. Remarking on findings from previous studies, Aries and Seider (2005) state that working class students talk about compartmentalising the different elements of the self, the authors found that some of the participants differentiated between the learner and social aspects of their identities. There seemed to be a dispositional coherence for their academic habitus but not necessarily for aspects of social habitus. Whilst the authors do not refer directly to student deficit in this study, the clear reference to working class habitus and field, and by implication, the difference between students’ background and their adjustments to the university is exemplified

Commentary:

Many studies which use Bourdieusian ‘thinking tools’, for example, Nicholson and Cleland (2017), Balmer et al. (2015), Bassett et al. (2018) and Wright et al. (2023) all tend to focus on the cultural and social capitals, whereas this particular study employed field and habitus. Despite four of the nine students having gained access to study Law (a popular and one of the elite disciplines), there were no working-class participants studying medicine. There was evidence within the students’ dispositions of self-scrutiny and self-improvement, possibly indicating reflexivity and agency. Four of the nine students were actively engaged with outreach work in non-selective state schools, attempting to encourage other non-traditional students to apply. Some of the key points emerging from this study, that I may need to explore in my study are, individual history or habitus, personal reflexivity and the potential to restructure the self, exploring experiences of FiF students, disjunctions between the fields of family and HE, and research which includes experiences of medical students.

Briggs et al. (2012) began their study by acknowledging the personal challenge of all students transitioning to HE but emphasised that the social displacement is intensified for mature, FiF students and those from ethnic groups. Additionally, that learners must create a new identity as an HE student for themselves. Despite students’ transition to university being a large-scale lifetime event, the authors believe the field is under conceptualised. Understanding of the phenomenon is explored through secondary sources from a considerable range of previous studies on student transition over a period from 1987-2019, and primary data from two investigations of student transition in the North-East of England. The first of the two studies was the Bridging the Gap project conducted in 2009 through interviews with 87 HE applicants, exploring expectations and experiences, ‘viewpoints’ from both sides of the bridge. The second study, Exploring Transition with first year students at a North-East of England university. The method for Part 1 utilised an online

questionnaire, with 1,222 completions, representing a 26.2% response rate. Part 2 of the study involved 74 students in focus group discussions.

Primary data collected from staff and students indicated that some students had difficulty envisaging university whilst others had opportunities to start building a learner identity through university interventions. The authors argue that support to 'bridge the transition' required students to reorganise their thinking about themselves as learner and social being, where transition involved learners creating a new identity for themselves. The authors perceive transition of learner identity to be:

- Imagining and aspiring to be a university student through the acquisition of related skills and knowledge,
- On arrival at university, adjusting to the academic environment ('field' in Bourdieusian terms)
- Acquiring confidence and autonomy (becoming agentic might explain this phenomenon)
- Finally, achieving success and full identification as an HE learner.

Two specific findings which I believe are pertinent in this article and useful for consideration in future research are: 1. Students want to be treated as individuals, not as an item in a vast system, and 2. the need to enable students to identify their own strategies for growth and find their own way to a new identity.

Commentary:

A strength in this study is the centrality of learner identity, clearly important for the trajectory into the HE environment. However, I don't believe it considers other potential and contemporaneous transitions, for example development of professional identity, or a new social identity. The point made by Briggs et al. (2012) of 'difficulty envisaging university life', invokes the Bourdieusian notions of capital (or assets), specifically 'cultural capital' and 'social capital'. Where 'what an individual knows' (cultural capital) might be restricted in families without experience of HE, such as FiF applicants, and social capital, 'who one knows' within a network of relationships, might provide contacts in the field of university life. Both these elements of lived experiences might be absent, or at best restricted. Potentially the individual's family, school, or people in their social milieu may not be able to provide any opportunities to learn about or make connections with higher education. My point above, in consideration of Reay's (2009) article, about the habitus of the organisation, specifically the medical school, is likely to transmute over time, with undoubtedly a gradual change in expectations of medical schools as they respond to Governmental, Medical Schools Council (MSC)

or The British Medical Association (BMA) social justice directives, as part of the stakeholder community.

We might conceive of the situation where the immediate family do not have the skills or experience to inculcate certain 'capitals' in their children. However, there may be other social connections and opportunities for vicarious learnings. Examples may be a schoolteacher or a parent of a friend who have experience within the associated medical professions, facilitating opportunities for work experience, or there may be relevant educational material in social media, which might provide learnings and a learner identity. Using a Bourdieusian lens (the framework of capitals outlined in Bourdieu's theory of social reproduction), assumes that family culture and the primary socialisation process essentially determines the future of the offspring. In terms of social mobility, and access to medical education, referred to in Chapter 2, some social theories, as in Bourdieu's framework of cultural and social capitals, may deny or discount the possibility of upward social mobility. While this critique of using a Bourdieusian lens may seem to be solely directed at Briggs' study, we can see that it is a common theoretical framework adopted to underpin much research within medical education (Gore et al., 2018).

Some key points emerging from this study, is a need to focus on identity and the perceived field of university life, and subsequently the adjustments required to transition to the new field. This acknowledges student variation in ability to cope with differences between the two fields, and potential for transformation of individual habitus, and contemporaneously evidence of agency. In terms of the potentiality for exploring agentic behaviour, and the alignment of the feature with Reay's findings, this may be a partial guide for structuring the proposed study.

Nicholson and Cleland (2017) using Bourdieu's social capital as a theoretical lens, considers notions of social capital and implications for WA to medical education. The study amalgamates data sets from three qualitative studies of student experiences of widening access to medicine. The authors suggest previous attempts to increase fairness of selection, to promote a higher proportion of under-represented groups have been ineffective. Furthermore, they remark, that an institutional assumption is that once admitted to medical school, disadvantage is no longer apparent, so students no longer need support. The authors claim that this is a flawed assumption. Their theoretical framework, using the social capital lens, was to move from the structural to the phenomenological level of analysis, in exploring experiences of those considering application to medical school or those who have gained a place. The purpose of the inquiry is to "explore the notion of social capital at a micro (individual) level" (Nicholson and Cleland, 2017, p.479), to gain understanding about contacts

who helped students to progress through the support received to provide knowledge of the field (life in medical school and healthcare settings).

The three separate qualitative studies consisted of:

> Study A: Three individual focus groups comprising senior secondary school students (from inner city, high socially deprived areas) or foundation students on WA programmes (Year Zero extended medical degree).
>
> Study B: An interview study with 14 first year medical students, describing themselves as from socio-economically disadvantaged backgrounds, under-performing schools or FiF to go to medical school.
>
> Study C: Mixed methods focus groups and individual interview follow-up.

Each study was originally analysed individually producing primary findings, with the three sets of data later being combined for secondary analysis of a total of 48 participants. Results from the combined data indicated three themes, namely:

1. 'On lacking the necessary contacts or resources.'
2. 'On social capital, widening access initiatives and other sources of information'.
3. 'On knowing what is important'.

Using this level of analysis of social capital, Nicholson and Cleland (2017) see this as one way to explore WP students' transitional experience as being distinctive. Additionally, they make a further suggestion that future research could employ a longitudinal study to explore temporal changes in individuals' transitional journeys. The authors also suggest that in addition to social capital, making contacts in the field of medical education would foster growth in cultural capital too, not only for pre-HE access, but also within the undergraduate programme. They found that lack of contacts was clearly evidenced in some of the narratives provided in the report However, on a positive note, there was evidence of medical school mentors supporting early transitions for widening access and gaining social capital (Nicholson and Cleland, 2017). This aspect of the study struck me as particularly worthy of exploration, in the case of existing medical students or junior doctors from similar backgrounds, 'giving back' and supporting future WA students.

Commentary:

As suggested in the article, researching early exposure to healthcare workers in medical settings would potentially support transitions at the personal phenomenological level, thereby increasing levels of understanding of and preparing for and within medical education. This highlights the

potential need for intervention and support of learners, not only prior to accessing university but also during the early years of the undergraduate programme. Effectively, recommendations for employing a longitudinal framework for this field of study by the authors, seems a creditable suggestion, along with a focus on the use of contacts to forge experiential learning, highlighting the centrality of both the person and the social, within a social constructionist paradigm. I believe that this work is both convincing and exemplary in the way lived experiences are captured through focus groups and interviews, and as a guide to indicate how future research might be positioned.

The key points emerging from this study, is the suitability of applying a longitudinal method to explore transitional experience over a requisite time and base the study on a phenomenological exploration of social experiences which have the capacity to enhance students' knowledge of the medical field. All participants across the three combined studies were from under-represented groups, including some who were FiF students. Some of these points may be useful considerations for inclusion in the proposed study.

Balmer et al. (2015) used a longitudinal study with 22, United States participants from their point of entry through to graduation, navigating the complex context of medical school, through a series of transitions, where students secure capital as knowledge and social connections in preparation for later phases of training. The researchers, wished to understand how the students experience the undergraduate medical education milieu from the preclinical phase to the major clinical year. They used Bourdieu's theoretical model as a lens for analysis, with notions of cultural capital and social capital, in line with other research adopting the Bourdieusian framework. Findings indicate that in the pre-clinical phase, students were engaged in teamwork to cope with acquiring the vast amount of knowledge (cultural capital) and who they knew (social capital). Balmer et al. (2015, p.1076) state that "fostered collaborative peer relationships… and perceived themselves as all on the same side (as) teammates, taking turns to teach each other". A supportive culture existed amongst students during this phase, but as they moved into the clinical phase, the field was less supportive and more competitive, with students vying for placements, "in order to be noticed" (Balmer et al., 2015, p.1079). Although this study may not be directly comparable with undergraduate medical education in the UK, the use of Bourdieu's other 'thinking tools' of 'field' and 'habitus' might have applicability in transcending the socio-structural level and adopting a phenomenological level of enquiry, again recognising the relevance of focusing on the individual contextually within the social world they inhabit. In terms of the institutional context and inherent assessment regime, the preclinical phase was pass or fail, and so the collaborative culture could possibly be a student strategy to ensure that they all pass. However, in the clinical phase it was grades which was the order of the day, possibly

changing the mindset of students and creating a competitive culture. The elements of the field changed from one of the medical schools, replaced by working in a health system with all its realities.

Commentary:

Whilst these findings might indicate a progressive series of transitions, within a non-UK setting, there is a comparable link with the Nicholson and Cleland (2017) study in respect of the nature and magnitude of support available, none of which appeared to be provided by the institution in this study (particularly in the latter stage of medical training). The key points emerging from this study are the nature of social structure within the organisation, which might impact considerably on the transition process, resulting on the type and level of support for academic learning. Additionally, students' personal dispositions and the self-regulation of identities, seem potential considerations to build into the exploration of transition.

An Australian study by Southgate et al. (2016), emphasises the necessity to make contacts, crucial to gain access to social capita in exploring what it is like to be a doctor and develop medical student and professional habitus. 21 students were interviewed focusing on three themes, namely:

1. The roots of participants' social mobility journeys,
2. How socio-cultural difference is experienced and negotiated within medical school, and
3. How participants think about their professional identities and futures.

The findings indicate students' describing getting to medical school 'the hard way', with many feeling like being impostors and using self-deprecating language, essentially highlighting their 'lack of fit', an example of imposter syndrome. There was some resistance to middle-class norms, with examples of a purpose to create a solidarity with their community of origin. "Rather than narratives of loss, students' stories reflect a tactical refinement of self and incorporation of certain middle-class attributes, alongside an appreciation of the worth that their 'difference' brings to the new destination, the medical profession" (Southgate et al., 2016, p.242). In terms of a journey of social mobility, the authors describe medical education as a vehicle to explore the costs and benefits of a transition through medical education. Variations in the findings indicated that two students had attended private schools, resulting from their family's considerable sacrifices, and only two had accessed medicine via the direct entry route, and five (mostly indigenous students) had come through university enabling programmes. Most participants, once having accessed medical school described their growth in self-confidence, though a few still reported feelings of impostor syndrome. The suggested limitations of the study were its single site and cross-sectional design of Years 1 and 2

of the degree, followed by a suggestion that longitudinal designs would more deeply explore intersections of social difference and provide an overview of creative adaptations of selfhood.

Commentary:

This study is one of many, in an ever-broadening field of exploration of WA, with its varying complexities and students from a wide range of lived experiences. In one sense it could be said that this design added the economic capital element to the social capital framework, in the context of social mobility, SES, and perceived class divisions. Key points emerging from this study are the authors' recommendation for future studies to adopt a longitudinal design to explore 'social mobility' journeys. This is particularly important when the purpose of research is to focus on aspects of change, such as learning and identity transformation. Additional noteworthy features of the study is the variation in students' previous background experiences, 95% had accessed medicine through 'access programmes, of which 24% were of indigenous heritage, and 2% of the participants had attended private education; associated features of social mobility journeys, for consideration would be identity, the adoption of selfhood, and exploring sense of belonging to an HE institution.

Bassett et al. (2019) studied 20 FiF students in one English Medical School (as part of an international collaboration) employing an interpretive epistemological paradigm and semi-structured interview method to focus on transitional journeys into and through medical education. Bourdieusian theory was used to explore the perspectives of medical students from FiF backgrounds, with a deductive approach to coding the data. The research focused on three periods of transition: Transition 1, was the journey into medical school, Transition 2 was the medical school journey, and Transition 3 was beyond medical school. The findings indicated that 90% of students' family were supportive of their application to medical school, though a third of teachers at school had discouraged them from applying; by implying they lacked intellectual capacity. I believe the impact of this could be two-fold, following the suggestion by Skinner et al. (2014), that either it lowered the expectations of the individual, or motivated them to rise above the teacher's assumptions and prove themselves to be successful, and others 'to be wrong'. In addition, a third of the participants suggested that they felt out of place amongst students from middle-class backgrounds which has implications for their 'sense of belonging'. Feelings of 'not fitting in', 'stigmatisation', instances of 'othering', and 'living in a different world' were common, as was overt examples of classism. However, there was little detail from the transcripts of this subtheme in the study report, 'Fitting into the Socially Mobile World of Medicine'. It would be interesting to explore if medical students from underrepresented backgrounds gain access to social and cultural capital vicariously from social media or other sources. The authors recommended both national and international longitudinal studies,

particularly to evaluate transition into medical practice for doctors from under-represented backgrounds.

Commentary:

The use of longitudinal studies of long-term transitional journeys, captured through semi-structured interviews could be both revealing, and would aid the future of medical education, in respect of equity and inclusion. Other than classism, aspects of 'othering' and relative 'sense of belonging', being featured in this study, I believe it is useful think about 'sectionality' and potentially other forms of perceived difference, or disadvantage, with subsequent impact on students' perceptions and transition through HE. Key points emerging from this study are a focus on 'first-in-family' medical students, using longitudinal methodology, and semi-structured interviews with an aim to explore potential feelings of 'not fitting in' and 'imposter syndrome'.

Wright et al. (2023) state that little is known about experiences of medical students from FiF backgrounds and wished to understand if the Canadian medical school environment could be exclusive and inequitable for these underrepresented students. They interviewed 17 self-selected FiF students and 5 students who identified as being from 'medical families' to test their emerging theoretical framework based on Bourdieu's concepts to explore the data. Results indicated the FiF students discussed the implicit messages about who 'belongs' in medical school and the challenges they experienced in making the shifts from their pre-medical lives to a medical identity. However, they reflected on their perceived advantages they had over their more privileged peers stemming from their less 'typical' social backgrounds. In their conclusions, the authors indicate that whilst medical schools take continual steps to increase equity, diversity, and inclusivity, they suggest a need for a structural and cultural change at the admissions stage and beyond. They suggest that going beyond social class in the context of inequities is necessary, as is a purposeful examination of what constitute deficit, and propose a substantial need to firstly move from the deficit model of underrepresented students needing, 'fixing' to allow them to fit the 'ideal' medical student assumption. Secondly, to shift the institutional focus on taken-for-granted aspects [the doxa] of the medical school environment which is perpetually creating social and cultural challenges for FiF students. Indeed, the authors suggest that over time, as doctors (and possibly tutors in medical education) FiF students may have a potential to begin to "shift the doxa of the health care field" (Wright et al., 2023, p.7). The role of reflexivity is emphasised in the study, where adopting a critically reflexive stance from, "the struggles and deficits of the individual to the culture and structures that may contribute to the inequalities" (Wright et al., 2023, p.8). Their conclusion suggests the doxa of the field should be redefined to value the capitals that FiF students already possess.

Commentary:

The impact of institutional culture on sense of belonging and transformations of identity, possibly resulting from assumptions around deficit, and the perceived weaknesses possessed by students from underrepresented backgrounds needs to be foregrounded. There may be a need for institutions to consider the inherent assets that FiF students might bring to medical education, not only considerations at the Access stage, but also during the ongoing undergraduate programme, and within clinical practice. Key points emerging from this study are issues around equity, diversity and perceived deficit; the existence of institutional doxa, and students possessing alternative assets, alternative to those often surfaced using Bourdieu's theoretical framework.

Theme 2: Review of literature which assumes an assets-based perspective

The studies within this theme are collated around an assumption that a possibility of alternative assets may exist, which have tended not to be recognised within the context of students transitioning to and through higher education. Such assets, both knowledge, dispositions and personal skill sets, possessed by students wishing to access HE and specifically medicine, are worthy of exploring.

Thiele et al.'s (2017a) article, 'experience of disadvantage: the influence of identity on engagement in working class students' educational trajectories to an elite university' made reference to Bourdieu's paradigm of socio-cultural reproduction for inequalities in student social mobility, and the plethora of studies devoted to Bourdieusian theory, however they argue that a wider theoretical lens should be adopted to capture, "diverse contexts and frames of reference within which young people are operating" (Thiele et al., 2017a, p.51). They also comment that a phenomenological approach to the qualitative enquiry was adopted, without an *a priori* (deductive) analytical framework. Additionally, the study took place in a Russell Group university, set against the backdrop of the group of HE providers with a tendency to have the highest entry requirements and higher inequalities in participation rates. The sample of participants was 13 high-achieving students from lower socio-economically backgrounds evidenced through their educational journeys from primary school to the university, via enabling or WP outreach entry programmes. The students were drawn from a cohort of 76 who had taken part in the WP programmes offered by the university, and the aim of the study was to enable students' voices to take centre stage' through in-depth interviews. The semi-structured interview schedule, composed of 10 open-ended questions, designed not only to elicit individual personal stories of lived experiences, but also to guide students chronologically through the key stages of their educational trajectories (Thiele et al., 2017a).

From the thematic analysis they identified the two latent themes of identity and educational engagement. Within the identity theme, three interrelated sub-themes were factored; self-evaluations, social comparisons (group identifications, e.g. social-class affiliations), and identity related expectations, e.g. perceptions of less likely to do well, or less likely to fit in (Thiele et al., 2017a). The educational engagement theme, referred to active involvement, commitment and concentrated attention to learning. The sub-themes identified from students' narratives were, attendance and decision-making behaviours. There were diverse accounts of student perceptions of attendance, difficult home circumstances impacting on attendance and an insensitivity toward students' shown by schools. Conversely, there were others having no issues with attendance and attainment, despite great adversity with home life. The authors believed that the transition to adulthood and HE coincide in this phase of life, with barriers and facilitators being perceived as meaningful by students, which varied across the individuals.

Commentary:

In my view, some of the strengths of this study are the phenomenological approach, use of semi-structured interviews to permit student voice and engagement with a chronological sequence of participants' lived experiences. Giving identity a position of centrality is a useful vehicle to explore educational engagement as evidence for progression and attainment, within the context of academically able individuals from disadvantaged schools, communities and home backgrounds. The students transitioned to a Russell Group University by means of a WP outreach programme. There are examples of personal dispositions of self-improvement and motivation to 'do better' and in some cases, to prove others wrong, (possibly an example of agency). Some teachers were particularly negative about student potential and were discouraging. Key points emerging from this study are the appropriateness of using a phenomenological position in methodology, with the intention of capturing the student voice to story their experiences of journeying through education and possibly dealing with some difficult situations. Additionally, it might be useful to consider if the application of Bourdieu's theoretical framework consistently accounts for the micro-level outcomes in the field of medical education.

O'Shea's (2016) research had previously highlighted a similar issue of students from FiF backgrounds being framed as 'in deficit' because they don't have the 'legitimate forms of capital' that are required by the HE institutions. Therefore, the author believes universities are manufacturing 'sameness' year on year because of their approach. O'Shea (2016) used Yosso's (2005) Community Cultural Wealth framework, to consider if FiF individuals indicated if they drew upon existing capital reserves (personal assets) in their transition to university. It was recognised that applying this specific

framework to O'Shea's (2016) data, is not unproblematic, despite Yosso's (2005) work being centred on critical race theory, migrant and gender studies, with a similar purpose of social justice. However, I would suggest that all forms of disadvantage and underrepresentation in HE is an issue for social justice and should be addressed at the institutional level. This might possibly be accomplished by critical consideration of firstly, the institutional expectations of the student, and secondly, what the current, wider base of student assets might be evidenced within a potentially changing nexus of the learning landscape.

It was believed that applying an alternate lens to the Bourdieusian paradigm might generate new knowledge, in that what is generally assumed to be a weakness in students may on reflection, be a strength. O'Shea (2016) reconfirms that numerous studies in educational inequality draw on the work of Bourdieu (1985) and critiques the way it elevates the nature of structure and social reproduction. O'Shea (2016) suggests that there are other unrealised forms of cultural knowledge that are equally valued by marginalised and less powerful groups, and critiquing the use of the Bourdieusian lens, "Traditional Bourdieusian cultural capital theory … places value on a very narrow range of assets and characteristics" (Yosso, 2005, p.77).

O'Shea's (2016) approach does indicate an alternate way to think about FiF student experience, thereby attempting to 'shift the doxa' imposed by HE institutions. I have previously referred to 'doxa' and a potential need to 'shift the doxa' in relation to the study by Wright et al. (2023), in Theme 1 of this chapter. The study involved 23 students from a range of disciplines in an Australian university located in a location with poorer educational outcomes and higher levels of unemployment. Participants had accessed degree programmes which ranged across the arts, science, health sciences and nursing, and although there was a school of medicine in the university, there were no students studying medicine who had self-identified as FiF. The findings indicate that various social domains and identities, intersected individuals and their experiences in higher education. The identities were diversly shaped by gender, age, social class, and ethnicity. The author intended that the differential capitals in Yosso's (2005) theory were not to be used deductively in the data analysis, but the narrated stories would be used to gauge if there was any alignment with these different capitals or assets, inductively.

Over time, there seems to have been a plethora of research studies, employing Bourdieu's framework, focussing on underrepresented students in HE from marginal backgrounds, including reduced representation in medical education. Both O'Shea (2016) and Yosso (2005) question the efficacy of using Bourdieu's social reproduction theory to explain the phenomenon of underrepresentation and the potential injustice it might indicate for understanding representation of

groups in universities and in certain professions. Essentially, the basis of Bourdieu's structural and social reproduction theory assumes that familial culture and primary socialisation with determine the future outcome of children. Effectively, upward social mobility is therefore likely to be at a low level.

Commentary:

There could be a possible Impact from institutional culture on students' sense of belonging and transformations of identity, possibly resulting from assumptions around deficit and the perceived weaknesses possessed by students from underrepresented backgrounds. Some of these may be conveyed by the institutions either covertly or overtly. Wright's (2023) and O'Shea's (2016) contribution to the field of FiF studies indicate a need to forego the 'deficit model' and focus on socio-cultural changes in medical schools. There is a need for institutions to consider the inherent pre-existing assets that FiF students might bring to HE and the possible messages conveyed to disadvantaged students. Such considerations apply not only at the at the Access stage but also during the ongoing undergraduate programme, and the approaches to learning within academic modules and practical skills training. Not manufacturing 'sameness' in student cohorts as O'Shea (2016) suggests, but instead, the need to genuinely celebrate diversity. Approaching the facilitation of learning may need to be modified to accommodate a broader range of student demographics and professional discussions of diversity. These aspects with be discussed in some depth in Chapter 7.

Underrepresentation of HE student groups across societies

From the breadth of reading the literature, across UK and International contexts, the underrepresentation of particular groups in HE is a common denominator within societies. However, students in both contexts (UK and international) tend to be demographic groups which are specific to the cultural and sociopolitical framework of the setting. For example, indigenous and students from rural areas tend to be the least represented groups in the Australian HE sector. Whereas, in the UK setting, social class tends to be the overarching factor influencing representation in medical education, specifically students from working class backgrounds. Whilst socio-economic status, within a specific society might be the overarching factor for representation in the higher education sector, the specific criterion for differentiation in social groupings may range across gender, ethnicity, social class, or other differing categorisations; the classification of groups within a society will vary between one country and another.

What is known (or suggested) from the literature

The use of a phenomenological approach would be beneficial, along with a longitudinal method and semi-structured interviews to explore transitional experience over time.

The overarching gap which transcends both UK and international research in the field of HE is the lack of knowledge of the personal, unique, first-person understandings of the internal transitional process for the student. It is worthwhile posing the question, how is the HE student, new to the field of medical education, experiencing their transition through the medical undergraduate programme?

To explore this question, I was sensitised to juxtapose the deficit perspective of previous research in the field, and the more recent perspective which considers that WP students may access the field with existing assets and not deficiencies. Coupled with these alternative perspectives is my supposition that the transitional process is a personal subjective one, based on the individual negotiating a pathway through their continual lived experiences. Hence a need to explore the transition phenomenon longitudinally to explore the individual representation of changes, in for example identity and skill capability.

Some of the key focal points within the reviewed literature in Themes 1 and 2 above, have been:

- Identity and adopting selfhood.
- Lack of preparedness and perceived forms of deficit
- Student diversity in the research, ranging across socio-economic status, ethnicity, age and forms of disadvantaged background.
- Sense of belonging.
- Interventions and support.
- Alternative perceptions of capital or assets.
- Doxa of the institutions.
- Recommendation of phenomenological approach and semi-structured interviews.

The gaps in literature

Some gaps in the previous literature review and indications for future research are:

First in Family: Several articles within literature in the field, refer to FiF students accessing medical education. However, the number of studies with FiF participants were limited, even at an international level. Exploring the lived experiences of students from these backgrounds, would be useful to pursue, based on the assumption that parents would not have the facility to inform their children about the nature of studying in higher education, nor obviously able to transmit knowledge of the medical profession. However, there is the possibility of FiF students of gaining knowledge vicariously through other means, e.g. the media, work experience, various WP Access programmes

provided by HE institutions or organisations like In2MedSchool (2024), with mentoring provided by current medical students and junior doctors.

Longitudinal research methodology: It appears that exploration of student experiences chronologically to capture students accounts of would lend itself to a longitudinal phenomenological approach and employing a theoretical lens that does not solely pursue a socio-structuralist paradigm. Ideally, it should be a lens that is more realistic in accommodating the relevance of the individual, and one which might view alternative capitals or assets, other than the often-applied Bourdieusian social and cultural capitals.

Other associated gaps indicated from the literature review are the centrality of learner identity, alternative ways of vicarious learning, students' personal reflexivity and the potential to restructure the self. The structure of the organisation and the nature and level of student support available are referred to in previous studies, along with the impact of institutional culture and doxa.

Theme 3: Theories and theoretical constructs within an 'identity as transition lens'

Within the literature outlined in the first two themes, there are overt or covert references to theoretical constructs which either have relevance for the findings of specific studies or potentially for future research. Unlike the first two themes, critiquing the research articles, the theme of this review section is to consider theoretical elements which might provide some explanations or contribute to the proposed inquiry of medical students' transition. I use the term theory (or theories) and constructs, as a set of assumptions and ideas to assist in explaining a phenomenon, in this case medical student transition and transformation of identity. It is worth noting that any socio-cognitive constructs, outlined within this section of the review, will be offered as a potential canvas for an inductive analysis of future narrative data (Kaufman and Mann, 2007). The constructs or theories will not be applied deductively to straitjacket the data into a predetermined framework, but allow the data, by way of students' voices, to emerge inductively. Van Manen (2016, p.7) reminds us that the "uniqueness of the individual is not necessarily generalisable".

Ontologically, the assumption for this workstream in Theme 3 is one of reality being multiple, with individuals seeking personal understandings of the world they inhabit, their worldview (Cresswell and Poth, 2018). Through social constructivism (Cresswell and Poth, 2018, p.24), individual students seek subjective meanings of their experiences and existence, with the researcher looking for complexity, and not narrowing down meanings to a few limited categories. Blaikie and Priest (2017, p.15) remark that worldviews are everywhere and over time the individual's worldview will change

because of new influences. The formation of a social actor's view is being determined by several factors, family, schools, community, an amalgamation of social relationships, within life's trajectory and experiences to date. And in addition to this, the experiences as they transition into, and through HE, eventually becoming a doctor.

The following concepts and theoretical explanations in 3:1 below have emerged within the research literature, outlined in Themes 1 and 2 of this review, outlining the possible social, cognitive, emotional, and behavioural aspects of underrepresented student transitions. Additional socio-cognitive constructs in 3:2 below is proffered as a potential collective framework, for realigning the bases for the intended inquiry of the transition of first-in-family medical students through the initial years of medical education.

Theme 3:1

- Identity and Sense of Belonging
- Identity Transformation
- Lack of Preparedness
- Lack of Institutional Support
- Equity and Diversity [and Inclusion]
- Deficit and Doxa

Theme 3:2

- Transition
- Identity
- Lived Experience
- Locus of control and agency
- Identity formation and Identity Work
- Self-Authorship and adaptions of Selfhood
- Self-Efficacy Beliefs and Skill Development

The range of literature reviewed here, collectively under theme 3.2, and explored in detail in Chapter 4, Theoretical Framework to ground the research, are as follows:

Identity as a lens for the transitional process (Gee, 2000); multiple aspects of identity (Sawatsky and Monrouxe, 2023); uniqueness of identity (Drew, 2023); and learner identity central to transition discourse (MacFarlane, 2018); narrative identity as internalised stories (Brown, 2022).

Transition as a contested construct, and as a typology of three conceptualisations of transition (Gale and Parker, 2014); transition being contextually situated (Crafter, 2012); transition as consequential on the relationship between the individual and a range of social activities (Beach, 1999); and transition as a process within a community of practice (Wenger, 1998).

Lived experiences central to storytelling and transition (Van Manen, 2016); giving meaning to personal experiences (Sartre, 1973); interpretation of lived experiencers (Heidegger, 2004); link with worldview and transformation of the person (Jarvis, 2006).

Locus of control and agency link between power and agency (Spencer and Doull, 2015); agency and meaning making (Allen, 2008); agentic behaviour and resistance to others (Konopasky et al., 2024).

Identity formation socio-cognitive, narrative, and discursive approaches to understanding identity (Monrouxe and Rees, 2015; Sawatsky and Monrouxe, 2023); professional identity transitions (Dickinson et al., 2020).

Self-Authorship internal capacity to define one's beliefs, identity and social relationships (Baxter Magolda, 2008).

Self-Efficacy Beliefs self-perception of level of competence in a variety of skills (Bandura, 1997).

I wish to emphasise that the potential for any of these constructs to align, and intertwine, will be ascertained inductively within the students' narratives, and subsequently during data analysis.

Research questions

The first research question was outlined earlier this chapter in the rationale for this review, which I repeat here along with the second and third research questions:

RQ 1. How do students, from first-in-family backgrounds, experience transitions through medical education in the early years?

RQ 2. To what extent does the study contribute to the theorisation of transition?

RQ 3. Are there any implications for how medical schools might support these transitions? 2

Conclusion

With the Aims and objective for this study, the overview of relevant literature in the field, and a focus on the research questions above, we now move towards a detailed exploration of relevant theory which underpins the study. Chapter 4, the Theoretical Framework, not only unpicks a range of crucial

constructs on transition, learning, and the transformation of identity, but also the impact on students' experience of their journey through medical education, heard through their voices.

4. THEORETICAL FRAMEWORK

Introduction

In Chapter 2, I considered a range of contextual matters related to widening the access to medical education and the justifiable reasons for this. I argue that a wider, potentially more diverse student population accessing medical education brings a much broader variety of social and learning experiences from the home, school, community, or possibly an access to medicine course. All these very individual experiences and the meanings students attached to them, will generate differences in a personal transition from their previous lived experiences to higher education and throughout their undergraduate course, which may influence their unique identities. In the previous chapter, I highlighted the potential for two sets of assumptions, first, a deficit-based perspective, and secondly, an assets-based perspective. Coupled to these is the cultural expectations of the institution, the doxa which might foreground expectations and the perceived fit between the students and the organisation. The particularities of the curriculum across the medical education programme are also of relevance to unique transitional experiences. It is crucial to be constantly aware of the impact which the institution may have on the transitional experience, the interface between the structural and personal. Interactions between individuals and the environment matter in learning and performance situations (Torre and Durning, 2015) and so it is important that we emphasise the social context and situatedness of the transitioning participants, as I conduct the inquiry and analyse their lived experiences, expressed through their individual narratives.

Crafter (2012) progressed understanding of transition, as being contextually situated, where change is influenced by some social situation which shifts the unique understandings of the self, which I believe underpins the relevance of both the individual and the social. In the specific context of medicine, and medical education, there is an expectation of regulatory stakeholders, e.g. General Medical Council, which requires that professional and clinical competences will be achieved throughout the training period. As such, all medical students will be subjected to learning experiences which will shift current knowledge and skill-based understandings and concomitantly trigger changes in self-perception and identity over time. Medical students' identity will change because of these learning experiences, identity transformations may therefore be seen as internal and personal transitions.

I emphasised the central position of identity in Chapter 3, specifically the self-concept of each medical student, making sense of their own idiographic experiences, throughout their personal and unique transition. The building of a transformative identity, potentially by means of reflective

practice, might utilise, either covertly or overtly, a range of conceptual tools to structure thoughts and substantive views of the structured self, a key point I took from the literature.

Whilst there is some published evidence of the experiences and identities of students' transition from school and college to, HE (Tett et al., 2017; Taylor and Harris-Evans, 2018), there is a scarcity of research on transitions during medical education as students progress through the undergraduate programme (Trautwein and Bosse, 2017; Sá et al., 2021). In the case of this inquiry, the early years of medical education are important for this stage of transition, as are the clinical stages and graduation to junior doctor. I believe it would be particularly important to engage in longitudinal research, detailing the personal transitional journey of WP/FiF medical students through to post graduation, to gain a more holistic picture of lived experiences and personal transitions (Van Manen, 2016). My research follows the first two years only, but it should be noted that for each individual, transitions are not fixed points but are ongoing, as is professional learning (Billet and Newton, 2010).

I take it as a given that identity, agency, learning, and transition, form a nexus of interconnected processes, which constitute transformations of human thought and behaviours. Whilst they are closely connected in several ways, I will initially consider each independently, to establish how each is conceptualised individually, prior to exploring their interface as a complex network of constructs. Throughout the study I will become sensitised and informed by the thoughts and meanings expressed by students, and potentially how these may add to the theorisation of medical student transitions.

However, prior to following this path of exploration, I wish to contextualise the way I am theorising and structuring this process, by adopting the concept of 'Bricolage'. In the French culture the term 'bricoleur' refers to a handyman who undertakes minor repairs and improvises technical solutions (Barnard and Spencer, 2010). Levi-Strauss (1962) applies the image to thought, which re-uses available materials to solve new problems, and Derrida (1978) extended the notion to suggest that we borrow our concepts from the text of our heritage so consequently, "every discourse is bricoleur" (Derrida, 1978, p.360). I intend to employ 'bricolage' in two specific, yet interrelated and reflexive ways.

Firstly, I apply it to myself, in my approach to theorising the theories around understandings of identity, agency, and transition, relating to learners' transformations through medical education. This is me the researcher as a bricoleur, utilising existing tools to build a conceptual framework purporting to represent thinking about transition and the transitional process. Reflecting on my lived experiences and transitional journey of leaving school without any qualifications, followed by acquiring qualifications part-time time and gaining a lecturer post at the age of 22, and eventually

being an FiF to access HE facilitates reflexive competency to explore learners from similar backgrounds. The structure of this conceptual framework is:

1. Identity (as a lens of the transitional process (Gee, 2014)).
2. Agency (as a means of self-directing elements in life).
3. Learning (by reflecting on ongoing experiences).
4. Transition (as an internally experienced process).

These aspects will be addressed sequentially in the development of this chapter.

Essentially, theory building to form a framework or new structure, will be inductively born out of the narrative analysis. As learners narrate their experience, they will effectively be building and remodelling in the telling.

Therefore, secondly, I wish to situate each student as a potential bricoleur, in the context of their reflections and rational considerations of transformations. We might view this as a personal structuring of themselves, which may be inductively explored during the interviews and analysis of personal narratives in the transcripts. Bricolage has been used to indicate a link between structure and agency (Phillimore et al., 2016). In summary, Rapport and Overing (2014) conceive bricolage as combining cultural forms to innovate, creating something new and perhaps more fit for purpose. With Phillimore et al. (2016, p.7) suggesting bricolage is "frequently viewed as being associated with originality and innovation, and the 'act of bricolage' as embodying individual agency and consciousness …."

The possible link between structure and agency, and indications of the individual enacting agency and consciousness is particularly relevant to this study, homing in on a students' conceptualisation of their personal transitional experiences. For this reason, the longitudinal exploration of personal transitional experiences through deeply considered narratives might not only reveal previously unexplored journeys through early medical education, but also a field which is for further exploration. In the context of educational practice, I believe that not only can researchers make meaning of students' transitions from their narratives, but individual students might also be coached to reflect on their own personal transition and consciously make meaning of the process. I will return to this form of empowerment later in the thesis.

As a 'bricoleur', re-using existing materials in the form of interrelated concepts in the field of learning, I will present what I believe are the component, albeit existing 'materials', which are relevant as tools to ascertain and understand these materials and how they coalesce. I will present

them in an order, beginning with 'transition', which I believe will give meaning to the composite elements of transitional experiences.

Concepts of transition

Transition and transitioning are contested constructs, and as such it is useful to explore how these are defined in the current literature. Gale and Parker (2014), in their typological framework of three conceptions of students' transitions, emphasised the uncritical employment of the concept in the context of universal HE provisions and widening access for under-represented groups. I believe there ought to be a critical lens applied to all concepts which may be used in a taken-for-granted manner in the field of education. This is not only important for institutions providing medical education but also for individual learners. What is meant by transition and transitioning? How do learners feel and perceive themselves, as they progress through the educational process? There have been several conceptual typologies of transition, in attempts to clarify how transition may be defined. Gale and Parker's (2014) typology of transition is viewed in three ways as 'induction' referred to as type T1, 'development' referred to as type T2, or 'becoming' referred to as type T3.

Transition as induction, T1, encompasses conceptualisations of transition as a fixed turning point or contemporaneous moment in time, a linear or vertical progression between say college and university, or Year 2 to Year 3 in an undergraduate degree. The implication for any perceptions of transitional movement in this category are as a structural, 'homogenous' one, an experience which is essentially viewed as the same for all students.

Transition as development, T2, is conceptualised as a shift from one identity to another, a trajectory of developmental changes. This perception of transition is perceived as a series of stages or phases, as opposed to a period, or point in time, as with T1 type induction. The implication of transition being developmental is in recognising that for all students there may be multiple points where transition is occurring. Additionally, the transitioning development or process will vary between students.

Transition as becoming, T3, suggests a more dynamic and ideographic account of student transition, one which is complex, multifaceted and an everyday feature of each life as it is lived, a condition of the student's subjectivity. Gale and Parker (2014, p.633) suggest that this conception of transition is, "least well understood" and is, "yet to be fully expressed in HE research, policy, and practice". My understanding from reviewing the literature is that there is very limited research on the medical students' perspective and voice on personal transition, or on examination of educational practice as one which accommodates an individual transitional process. Exploring transition through a process

of becoming, in the context of recognising the HE student body, as more diverse, and students as having individual realities offers a more authentic direction for exploration.

Another conceptualisation of the transition process is that it may not necessarily be a moment in time, but an experience of progressive change and, additionally that transitions are consequential for the individual and the institution (Beach, 1999). Beach (1999) developed a dualist, 'person-environment model', a form of interface ontology between objectivism and constructionism, an interactional position between the social and individual. Effectively, this suggests that the personal transition for the individual is a consequence of some social experience, hence a consequential process. An example of it being consequential for students might be their engagement with patient and carer communities, and practise in communication skills or taking blood or canulating a patient during clinical placements. Students are likely to change because of these learning experiences. Could it be that FiF students have more disjunctions in learning if they possess self-deprecating thoughts about their suitability for medicine or display 'stereotype threat', the situational predicament, where individuals have feelings which confirm a negative stereotype about their social group (Steele and Aronson, 1995).

However, we cannot disregard the potential reciprocal changes for the institution (or even required of the institution) which I outlined in Chapter 3. In respect of the doxa of the institutional field, there exists a potential of the organisation to redefine the delivery of medical education. This might be the acknowledgement and valuing different kinds of capital that FiF students already possess and bring with them to the undergraduate programme and the health service context.

Beach (1999, p.114) remarks, "transitions are consequential when they are consciously reflected on, often struggled with, and the eventual outcome changes one's sense of self and social positioning". The developmental change is therefore viewed as a relation between an individual and several possible social activities. Beach (1999) elaborates on his binary ontological position in suggesting four types of transition as follows:

1.	**Lateral Transition** Unidirectional, individual progression (vertically). This is an upward linear movement dictated by institutionally organised direction.
2.	**Collateral Transition** Multidirectional, co-constructional and occur more frequently in the learner's lived world. Tendency to be more horizontal in nature.

3.	**Encompassing Transition** Individuals move within a community to become 'full participants' of the social community as they adapt to existing or changing circumstances.
4.	**Mediational Transition** Simulation activities in preparation for future activity (vocational / adult education and training).

Table 6. Types of consequential transitions (Beach, 1999).

Beach positions his **lateral transition** as a classic transfer, which I believe aligns with T1 in the Gale and Parker (2014) typology, whereas his **collateral transition** tends to run parallel with T2 of the typology. What I find more applicable to educational practice are Beach's (1999) other categories of transition. **Encompassing transition** suggesting a community of practice theoretical framework, akin to that expounded by Wenger (1998). I believe that a community of practice is valued more in medical education because it is not only a means of facilitating progressive learning in the field, but also a place for knowledge evolution which relies on workplace learning within an evolving practice. In medicine, this form of transition essentially embodies the context or place for practice, whereas **mediational transition** arguably alludes to the context for medical students to engage with simulation of clinical skills, with say manikins or communication skill workshops with volunteer patients and carers.

In terms of clinical skills and communication skills training, any potential examples of shifts of identity which emerge in the research data may be a consequence of specific training or educational activities. This proposition offers some alignment between Beach's (1999) model and Gale and Parker's (2014) T2 type of transition (as development), jointly with the T3 type of transition (as becoming). Both these elements, and Beach's (1999) construct of 'mediational transition' arguably represents a developmental transition of becoming, developing as a more competent student, towards becoming a competent and professional doctor. Although, the limited parameters of this specific inquiry do not allow for analysis of long-term transitional accounts from new medical student to doctor, the findings from the first two years of medical school may reveal areas for future research in this field.

Some summary points of transition

To summarise implications of the nature of transition from theoretical discursions, I conclude that:

- ‘Becoming’, which might be considered dynamic, expresses the nature of a movement through a lifetime of lived experiences, a movement (or process) which is dynamic, multifaceted, and personal.
- The subjectivity of the transitional process is contextually (socially) situated, underpinning both individual and social factors.
- The process emphasises experience of change, with the individual potentially indicating some level of agency.
- The outcome of the process, results in a change or shift in self-identity which supports transformative learning to meet current and future challenges.

A group of interrelated concepts have been framed to explore what I am choosing to call a personal process of transition.

Concepts of identity

“It’s in the telling of the story, we learn who we are and who we may become”.

(Yorkey, 2020)

Identity may be defined and theorised in several different ways, with a variety of explanations as to its formation.

The quotation above is by one of the principal actors during a post-production seminar following the completion of the Netflix series, 13 Reasons Why. The discussion with several actors, the producer, director, and a practicing therapist, pondered how each of the characters, portraying teenage / young adult roles, was wrestling with their perceived identity and who they believed they were becoming, whilst reflecting on their previous lived experiences. However, I found this quotation particularly appealing in the context of my study, because the characters, from a variety of ethnic backgrounds, had experienced some levels of disadvantage, requiring considerable deep reflection and ‘identity work’ to make meaning of their lives and potential futures.

My reason for including the quotation here is two-fold. Firstly, to consider one way in which we might internalise an image of ourselves, as an autobiographical narrator, through discourse with another person or persons, Wortham (2001) suggests that in a storytelling event, the narrator may partly construct the self, by positioning themself with respect to the audience. Secondly, self-representation may include past self or projections into the future, for example, this is who I was, who I am now, or who I am becoming. This ‘who I would like to become’ discourse with a medical

student could be useful in respect of facilitating reflections on professional identity development. Regarding meaning making Gee (2014, p.181) suggests that narratives "are important sense-making devices" for individuals, where they encode problems which concern them, along with their attempts to resolve the problems.

This proposition links to Jarvis' (2006), and other authors' viewpoint that the impetus for a learning episode (or cycle) is a point of disjuncture in our thinking, or in the extreme case, an existential crisis in our life. As a specific example of moments where dissonance or disjunction may occur in thinking and learning for medical students' thinking is in the context of developing professional identity, also a critical moment as part of transition. There may be dilemmas where a student may find it difficult to resolve potential 'boundary issues' between the professional and personal domains of their lives.

Given this understanding of transition, narratives and self-narration (either internal or external) hold a central position in this inquiry. Firstly, from a students' perspective, in how they will reflect themselves in their narrative during interview. Secondly, as they tell their story for me as researcher, and how likely I am to shape the narrative through the type of questions asked, reflecting my positionality. My positionality and internal narrative of lived experience is constantly addressed reflexively in the research, as was the use of a critical narrative review methodology for the Literature Review in Chapter 3. The findings from the supplementary data in Chapter 7 indicate how the participants valued their reflective practice in curation of personal narratives throughout the longitudinal interviews.

We could perceive self-identity being composed of numerous elements, each of which may be related to a different point in our life history, or the roles we are playing in a specific social context, or others with whom we are interacting at a specific point in time (Gee, 2014). In the context of medical education and training, this might be peers, tutors, patients, and contemporaneously, a partner or members of our family. Personal identity refers to the characteristics and qualities of who I am and who am I becoming (Sawatsky and Monrouxe, 2023). The multiple aspects of our identity, possibly made up of our gender, ethnicity, religion, profession, values and beliefs, amongst other potential features, make us unique (Drew, 2023).

Whilst individuals may self-identify uniquely depending on the selected represented elements of their being, it may well be the aspect of 'learner identity' which holds most relevance for HE success (MacFarlane, 2018). MacFarlane (2018) suggests that central to the discourse on transitions, is the concept of learner identity. In the context of learners from disadvantaged backgrounds who have unequal access to HE, and especially those who are first generation students, bridging this gap

between school and university learner identity takes on a heightened significance (MacFarlane, 2018, p.1202). Other interrelated psychological self-constructs which are integrally functional to the conceptualisation and understanding of self-identity are:

a. Self-esteem: how much you like or value yourself.
b. Ideal self: what you would like to be, or become, in the future.
c. Self-efficacy beliefs: your perceived level of competence on specific skill domains.

Summary points: Of identity or self-concept (a collection of beliefs we hold about ourselves)

- Ability to reflect on past, current, and future self (through co-constructions with others)
- Narrations from story-telling events can surface concerns or problems for potential resolution
- It is apposite to the various aspects of self and others in consideration of diversity and inclusivity.
- Relevance of learner identity (e.g. self-efficacy belief of being a self-regulated learner)

Concepts of agency, power, and agentic behaviours

It is important that we consider our understanding of agency and our usage of the term in relation to learning and personal transition. Locus of control is a term referring to how much control an individual feels they have in their own behaviour. They can either have an internal or external locus of control (Rotter, 2017). Rotter (2017) proposes that people with an 'internal locus of control' are more capable of resisting social pressure to either conform or obey, possibly because they feel more responsible for their actions. I believe that an individual's belief in their ability to resist social pressure may be impacted, in part, by socio-political and cultural expectations within specific contexts. The aspect of power in relation to agency is central to how we might investigate the two concepts (agency and power), examined by Spencer and Doull (2015). It may be that we, superficially, regard an individual whom we assume to have agency to be, "social agents who are active meaning-makers in their own lives rather than simply the passive recipients" (Allen, 2008, p.565) of others. Discussions in this area involve structure versus agency dualisms and philosophical debates around possibilities of 'free-will and determinism'.

As researchers, our ontological and epistemological position, will likely affect how we define agency, and investigate and interpret students' expressed experiences of 'agency' (Spencer and Doull, 2015). Their typological summary of four conceptualisations of power are as follows:

	Concepts of Power	Explanation and Application
1.	Power to:	Individual's capacity to act and influence others. Intentionality to affect others.
2.	Power within:	Individual's belief in personal mastery and control over events and actions, e.g. development of own self-esteem and self-efficacy beliefs.
3.	Power over:	Various forms of domination, e.g. overt, and covert control over other people.
4.	Power through:	Ideological forms and micro-politics of power. Power to shape dominant norms and ways of knowing.

Table 7. Conceptualisations of power (Spencer and Doull, 2015).

Spencer and Doull's (2015) concept of dispositional empowerment suggests "that agency resides within the individual" (Spencer and Doull, 2015, p.904) and support for this conception within the data, might be examples of narratives which demonstrate enactments of agentic behaviours, e.g. examples of resistance recalled by participants (Konopasky et al., 2024). Whilst Spencer and Doull (2015) believe that contradictions may arise around the structure/agency dualism, the difference between opportunities for the individual to act, and how much they believe they can act. I believe we ought to consider the thoughts and feelings of the individual, and not just examples of observed agentic behaviours. We can consider a student's agency, by means of their recollections of actual behaviours or an affective experience, both of which may impact on their identity through their engagement with personal meaning making of transition.

Metacognitive forms of reflection that students adopt might internally track their own progress and sense of agency through the educational programme, and this aspect I wish to explore within the analysis of the participants' narratives of lived experiences. For me to be reflexive and not be singularly invested in merely one conception of agency, I will consider possibilities, within the narratives, of students' impressions on their thoughts on being powerful agents. In this sense, I will consider, amongst other criteria, what students from FiF backgrounds bring to higher education. I believe that this will assist in delivering more clarity in the research process to reveal the varying forms of privilege in the medical education landscape.

Central to human agency, is the agentic property of 'self-reflectiveness' (Bandura, 2006) particularly when we evaluate self-efficacy and how it might impact on shifts in identity. Bandura considers self-efficacy as the "most distinctly core property of human agency" (Bandura, 2006, p.165) I am specifically interested in exploring evidence of this in the data, particularly with regards to medical

students' self-evaluations of skill development, e.g. communication or clinical skills, developed in placements settings, or simulation exercises on campus. In addition to the personal benefits of agentic thinking and behaviours, Ng-Knight and Schoon (2017, p.2116) suggest that "internal locus of control may be a considerable resource factor" and, "may compensate for background disadvantage". This position is supported by Heckhausen (2021, p.441) who suggests that "once youth from less educated backgrounds attain admission to university, they do better than their more privileged counterparts."

Figure 1: A process of experience, reflection and curation of agency.

Similarly, Rutenberg et al. (2021, p.1019) consider the impact that agency may have on improving academic performance in first-year university students and chose to use Bandura's (2018) model of agency which includes motivation, self-efficacy and perceptions of control. If we consider the power of agency to perform well academically, despite the level of parental education, it may be possible to question the validity of deficit theories surrounding underrepresented student groups. However, I will leave that question for the discussion and conclusions in Chapters 8 and 9.

The ongoing socio-cognitive processes of reflection and self-evaluations, and the impact on identity and personal transitions, are integral to my pursuits in this study, and it is the centrality of learning, especially self-directed learning to which I now turn.

Concepts of learning

Not dissimilar to transition, there has been a broad range of conceptualisation of learning and processes of learning. Jarvis (2006, p.9) refers to his first model of learning, that he produced in 1987 to overcome the perceived deficiency in the complexity of learning in Kolb's (1984) learning cycle. As with Kolb (1984), Jarvis' first model suggests a cyclical process of learning; a series of iterations over time (Jarvis, 1987, cited in Jarvis, 2006, p.9). This model, he referred to as the process of learning, consisting of several seemingly interconnected nodes, some of which are inter-relational. However, I believe that this earlier model does not contain a central-processor node, which accommodates some form of synthesis of different elements of a learning process, one which can simultaneously integrate cognition, emotions and previous behavioural responses.

Jarvis (2006, p.23) produced his second comprehensive model of human learning (Figure 2. below), specifically referring to human learning, as distinct from theories of learning derived from research with non-human species. His definition of human learning is, “the combination of processes whereby the whole person – body and mind (knowledge, skills, attitudes, values, emotions, beliefs and senses) experience a social situation, the perceived content of which is then transformed cognitively, emotively, or practically and integrated into the person’s individual biography resulting in a changed (or more experienced) person” Jarvis (2006, p.13). Interestingly, the conceptualisation of learning in this model is not only its comprehensive level, indicated by the multiple components, but also how the elements equally capture the individual and the social; the history of the individual in their social world, and how they transform their identity through reflective thought.

Figure 2. below outlines Jarvis’ (2006) second model of learning, which continues to frame the individual within their social world, though I believe additionally encapsulates the essence of a transitional process, which is central to this inquiry.

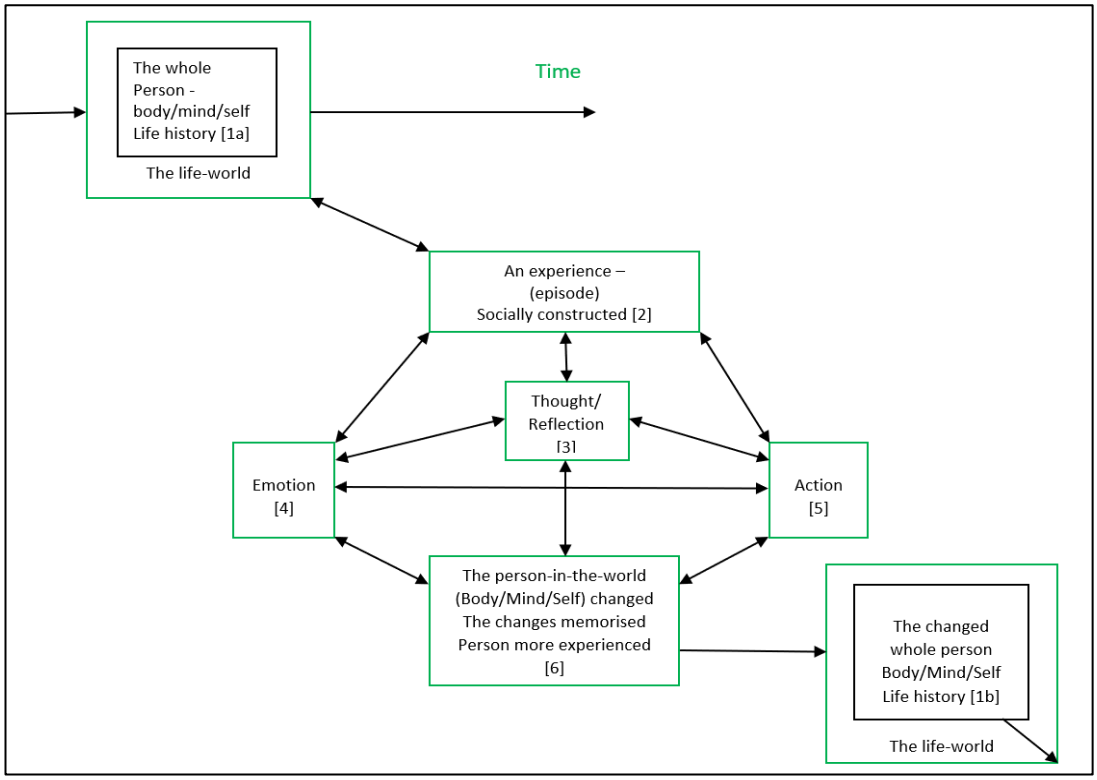

Figure 2. Model 2. ‘The transformation of the person through learning’ (Jarvis, 2006, p.23).

This reconfigured second model by Jarvis (2006) above, implies a change in identity due to learning, and accommodates reflection on previous experiences, and possibly the way learners may resolve feelings of unease or disjuncture, not only indicating a point in learning for the individual, but also

how they are likely to perform in the future. It is the rational, existential thought, often imbued with emotion which are 'moments of learning', memorised for future reflections on the way to proceed in similar circumstances. The phenomenological position, which I pursue, is to consider experience as a unit of analysis by encouraging participants to make conscious how they understand their own learning and the transitional process. I interpret the overall framework of Jarvis' (2006) model in relation to the context of my study as follows.

Life history in the lifeworld

The lifeworld, as experienced by the individual, where points of learning might be a student's thoughts about experiences of childhood/primary school, secondary education, and their tertiary education journey, which becomes part of their life history. A series of learning events through interactions with significant others in their life world, is where social identity develops e.g. 'I am working-class', 'I belong to this ethnic group', or 'I feel that I am in control of my own learning'. The limitation is that I am not doing a life history study but merely foregrounding the students' narratives of lived experiences with some context of home, early school lives, and possibly experience of a WP enabling type programme.

The person-in-the-world changed

The model provides an opportunity to consider narratives and how they become life stories about the self and change over time, hence the need for a longitudinal study. In my study, I propose to capture participant narratives which identify any potential changes in belief, attitude, knowledge, or skill, which might signify an internalised transition or identity shift. Examples of thinking might be, 'I am this now, but am becoming something else, a doctor, girlfriend/boyfriend, a more confident presenter in tutorial groups, or a medical student capable of cannulating a patient'.

Thought, reflection, emotion, and action

Jarvis (2006) suggests that 'disjuncture' is usually the cause for our learning, a point in our thinking where some level of dissonance triggers a disruption in our harmony, or 'taken-for-grantedness' of the lifeworld. Focusing on the inner and outer domains of the learning process, and the variation of the specific social context for learning (the outer or external factors) the unique experiences of the students are likely to create variability in the specifics of transition. I consider that there may be triggers or prompts that initiate further learning or reconfiguration of personal knowledge, but it may be quite different for each student. This might depend on the individual starting point of their existing self-knowledge and possibly the intrinsic motivation to realign current and future

understandings. There is also scope in this study to consider the relevance of emotional intelligence (Goleman, 1998), an additional factor which may impact on the learning and transitional trajectory.

Capturing emotive, disjunctural moments, through reflection and resolutions in thinking, could serve as a proxy for the perceived transitional process within the learner. Therefore, this may be the why, explaining why there is transition or becoming (in respect of identity transformation), particularly when focusing on the intersection of the inner and outer domains of the learning process, self-knowledge that is socially constructed. What is the trigger to start a learning episode, is it intrinsic or extrinsic? The learner may voluntarily wish to pursue a new line of enquiry to expand understanding, which would incur intrinsic motivation, or it may be initiated by extrinsic motivation, a specific element of the medical curriculum which is formally taught and is required to be mastered. Either way, it would be useful for students to be cognisant of their thought processes and transitional development.

There may well be variation of the specific social context for learning, the outer or external factors, and the past experiences of the student are likely to create variability in the specifics of a unique, personal transition. There exists an intersection between the personal and the social, what the learner brings to the education process and what the institution provides. However, the actual transitional process of learning and becoming may have commonalities for all students, despite differing personal approaches to learning and learning outcomes. I believe that Jarvis' (2006) model has the capacity to provide insights for my enquiry in exploring how FiF medical students begin to understand their own transition, uniquely and subjectively. It may be that FiF students experience multiple disjunctions, which may need exploring in the study. However, we should also distinguish between the 'what' of learning. Is it self-knowledge, what the individual is learning about themselves over time, e.g. various self-beliefs or thoughts on wellbeing, or is it about learning the medical curriculum? In one sense they are different, but in another, they are interconnected. Nevertheless, it will be useful to consider the spectrum of learnings in the study through the evidence in students' narratives.

To interrogate some approaches to understanding the essence of learning, particularly as there have been a breadth of understandings of learning over time, I believe it is useful to review a range of metaphors which purport to offer insights into learning processes, and their potential application. Earlier theories of learning tended to locate learning within the learner, particularly from an individual cognitive perspective, and not take account of possibilities for social learning. More recent paradigms of learning recognise that we learn through contextual activities where the learning is both situated and social.

In discussing metaphors of learning, Hager, P (2008) notes the limitations of the constructs 'acquisition' and 'transfer', often used in psychological explanations of learning relating to memory, e.g. short-term to long-term memory. With Hager and Hodkinson's (2009, p.619) bid to move "beyond the metaphor of transfer of learning", they considered the use of the 'participation' metaphor drawing on Lave and Wenger's (1991) seminal work on communities of practice (CoPs) where learning is contextualised in an established socio-cultural setting. They also point to weaknesses in the participation metaphor, in that there are likely to be several contexts for learning, not merely a single setting, as reflected in Wenger's (1998) earlier consideration of a permanent organisational, community setting. Secondly, they consider that in emphasising the social aspects of the 'participatory process', the life history, personal dispositions and agency of the individual may be lost. I consider learning by participation in a CoP context, to be applicable to medical education and training, where students are engaged in a variety of rotational clinical practice placements, and will learn progressively from that engagement over the course of education and training. Wenger (2015) latterly developed his conceptualisation of community of practice to incorporate multiple communities, as 'learning in landscapes of practice'.

We might 'plug in' the becoming metaphor for learning, to Wenger's (1998) social learning CoP theory, where Hager, P (2008) refers to 'becoming' as being socially embodied through physical, emotional, and cognitive strands, where the learner reconstructs knowledge with others in specific social contexts, whilst simultaneously reconstructing herself/himself through shifts in identity. He argues that people 'become' through learning and learn through becoming (Hager, P, 2008). This is also in keeping with Jarvis' (2006) model of transformative learning and supports my belief that learning, as becoming, starts in the early years before formal education. Early lived experiences in the home and primary school undoubtedly shape attitudes towards learning, and as such, I believe that this will render learning, and the transitional journey, personal and idiographic in nature. Additionally, my understanding is that with 'becoming' being conceptually embodied, and identity being reconstructed by the individual, one's identity involves a much deeper shift. There is a subtle difference between identity and identification, where the substance of our identity may be deep-seated, whereas we may identify with a group of others perhaps only temporarily, and possibly superficially, as we practice with them together at a particular point in time.

How learners reconstruct themselves then, is influenced by the person they had become initially through socialisation in family and school, prior to starting in HE, Hager, P. and Hodkinson (2009, p.633) believe that learning as becoming is never complete and with the metaphor of becoming, there is no clear endpoint to learning. Consequently, 'becoming' as a construct for transition is clearly useful to explore, through medical students' perceived changes in identity, the personal

adjustments they make on entry to medical school and throughout the subsequent years beyond graduation.

In terms of using or ranking the perceived appropriateness of metaphors for learning, we might be guarded against an over reliance of their use. Sfard (1998, p.5) suggests that metaphors, "…are what makes our abstract (and scientific) thinking possible; on the other hand, they may keep human imagination within the confines of our former experiences and conceptions." In this sense, we might say that a metaphor might free up our thinking, when theorising around a concept such as learning, but contemporaneously it may also be restrictive, leading to barring new insights and perpetuating, "beliefs and values that have never been subjected to a critical inspection" (Sfard, 1998, p.5). In summation, Sfard considers that, "…too great a devotion to one particular metaphor and rejection of all others can lead to theoretical distortions and to undesirable practical consequences" (Sfard, 1998, p.5). Sfard's point on not being reliant on one metaphor might be a guide for the researcher to avoid analysing data deductively with an assumption of a single metaphor and be open to the possibility of different forms of learning across a range of practical situations, contexts, and the possibility of differing styles of learning amongst students.

The range of theoretical frameworks of learning within an 'acquisition paradigm' reviewed by Sfard run historically through constructivism, interactionism, and sociocultural theories Sfard (1998, p. 6). Within the latter paradigm, social constructionism there is the consideration that knowledge is constructed by the student, including, through participation in particular activities. The relevance of 'practice' and of 'doing', indicates I believe, some alignment with Beach's (1999) concept of a mediational transition and also with an element of Jarvis' (2006) model, which proposes that learning incorporates practice and experimentation. In the context of medical education and training, there are requirements for practice (General Medical Council, 2023) and, in some cases, simulation activities (Al-Elq, 2010), to become fully competent in practice.

Some Summary Points of Learning:

In summarising the theories and models of learning discussed, I conclude that:

- Each moment of learning is building on previous learnings within our life history.
- We are learning continuously over time, and simultaneously 'becoming' a different person.
- Learning is situated in a social context, where some constrictures might interface with personal agency.
- Learning includes reflection on thinking or behaviour (past, current, or intentional)

Summary

This chapter has emphasised the centrality of identity, agency and learning, and their potential constitution for a personal process of transition. A process which is to be explored through students' narration of their lived experiences and considerations of transformational changes in their identity, up to the point of accessing medical education and during the first two years of the undergraduate programme.

My consideration of both theory and specific constructs to be employed in this inquiry are the means of progressing the research. The following chapter encompasses both philosophical thinking and strategic decisions to determine the application of appropriate methods for this study.

5. PHILOSOPHY, METHODOLOGY & METHOD

Introduction

From the previous chapter which built a theoretical framework and highlighted relevant concepts potentially aligned with the proposed study, this chapter outlines the underpinning philosophy, methodological bases, and a chosen method to undertake this study.

Philosophy

I am re-presenting the research questions provided in the literature review, Chapter 3, to focus on how the philosophical and methodological foundations provide direction toward the most appropriate approach for the method to undertake this inquiry.

Research questions

RQ 1. How do students, from first-in-family backgrounds, experience transitions through medical education in the early years?

RQ 2. To what extent does the study contribute to the theorisation of transition?

RQ 3. Are there any implications for how medical schools might support these transitions?

Exploring medical students who are the first in their family to access HE is the purpose of this study. How an individual perceives and feels they are progressing through their life, the educational programme, relationships with friends, family, peers, and tutors, is central to their being and becoming - their existence, This study seeks to establish an understanding of medical students' unique transitional experiences, and therefore existentialism, is one philosophical position, which is pertinent to the phenomenon 'transition' under consideration in the study. Although many branches of philosophy will consider crucial questions concerning the nature of knowledge, truth and meaning, existentialists ponder how those questions are particularly significant to the lived experiences of individuals (Ozmon, 2016).

Existentialism and the person in the world

Ozmon (2016) considers a number of existentialist thinkers and reviews the ideas of Sartre (1973), who believed that human existence is meaningless as individuals are thrown into a world without meaning, so any meaning has to be constructed by the individual. Sartre (1973) suggests the relevance of agency of the individual in respect of meaning making. I believe that only by existing

and acting in a certain way do we give meaning to our lives - we exist, and this precedes the essence of our being. However, we might consider that meanings perceived by individuals in their early lives, as a person in the world, are lived experiences which may come through the socialisation provided by family and various significant others throughout their lives, which provide a form of ready-made meanings or belief systems. I referred to the aspect of 'taken for grantedness' in Chapter 4, which might apply equally in the culture transmitted through the family or through institutions. Despite whether we might consider the person in the world as being 'determined' by external social forces or the ability to exercise 'free-will', by possessing some level of agency, is a moot point which could likely align us to one paradigm compared to another. This chapter focuses on my specific philosophical position, methodological assumptions, and particular method for data collection, to ensure a level of methodological congruence (Richards and Morse, 2013). This requires that the purposes, questions, and methods of research are all interconnected and interrelated, so the study is a cohesive whole.

Ozmon (2016, p.200) suggests that educators, and I include myself here, who could regard themselves as existentialists and, who might propose the central aims of education, or a specific type of curriculum, should focus on the authentic existence of a learner being-in-the-world, and having the agency to comprehend and narrate their own lived experiences. A pedagogical corollary of this would be valuing learner-centredness and focusing on the facilitation of learning as a non-directive practice, which is expounded by Ozmon (2016, p.203) that "existentialists believe that students can and should discover knowledge through their own efforts and that the role of teacher is to act as a guide or facilitator in the learning process." I believe that adopting an existential philosophical position is not only appropriate as a starting point for the intended study, but also in respect of potential data that may be revealed by participants regarding their higher educational experiences in the world of medical education.

There is some alignment between an existentialist perspective and Jarvis' (2006) model of human learning referred to in Chapter 4, where the individual, the person-in-the-world, is responsive to experiences in the environment, and through volition will think, reflect, and act on an experience in a unique, personalised way. Existentialists subscribe to the idea that a good education emphasises individuality and the initial step in any educational journey is to understand ourselves (Ozmon, 2016, p.1185). This seems consistent with the maxim of the ancient Greek philosophers, e.g. Socrates, 'Know Yourself' which involves the skill and practise of deep reflection and reflexivity.

Phenomenology, and lived experience

There is close correspondence between existential and phenomenological philosophy, where phenomenology studies consciousness as experienced from the first-person point of view. In Husserl's (1969) main work 'Ideas', his principal aim is to make philosophy a rigorous science, to distinguish it from the physical and behavioural sciences. This essentially, seeks to study the individual's intuition of things outside the physical body, prior to interpreting and making meaning or sense of them. This might simultaneously consider any previous learning or prejudice an individual may have. Subsequently, Heidegger (2004), in following the methodology of Husserl (1969), in enhancing its usage to include 'hermeneutics', defined as the interpretation of lived experience. In the context of my study, there is a requirement to facilitate reflexivity in the participants, for them to consider and interpret their lived experiences and transition through their medical education.

Phenomenology, hermeneutics, and narrative accounts

Understanding the lived experience is the cornerstone of the intended study, specifically in relation to the potential for learners to begin to understand their own unique journeys of transition. Hermeneutics focus on the internal process, through language, to disclose to others one's thinking and making meaning and understanding clear to oneself. This process has relevance for education and for some therapeutic techniques, areas which are regarded as 'person-centred', according to Gadamer (1970). His principal value of hermeneutical phenomenology is the educational value of self-formation or 'bildung', the concept which I introduced in Chapter 4 and will return to in Chapter 8. This branch of philosophy concentrates on interpreting the texts of life and lived experiences (Howell, 2013). Furthermore, both Gadamer (1970) and Ricoeur (2008) shift the point of phenomenology from a descriptive mode (outlining phenomena) to a linguistic mode, which focuses on dialogue. This implicates the means by which it is possible, through dialogue, to be in touch with our personal/social life and be conscious of the ever-evolving lived experiences (Van Manen, 2016). This is where 'internal conversations' (reflections), and external conversations with others, have the capacity to curate meanings about one's transition over time. It is intended that the style of interviewing adopted in this study will significantly encourage research participants to be agentic in their thinking and adopt the essence of hermeneutical phenomenology, as indicated in Table 7 below.

Philosophical position	Proponents of the position
Transcendental phenomenology: Focus on the individual's first-hand perception of the external world through the senses, e.g. sound (I hear 'w'), sight (I see 'x'), smell (I smell 'y'), or touch (I feel 'z'). A concentration on what is believed or even desired, rather than the recognition of consciousness.	Husserl (1969)
Hermeneutical phenomenology: Focus on understanding the lifeworld and existence by meaning making. The world and consciousness of it are not separate, they are a holistic construction of lived experience.	Heidegger (2004) Gadamer (1970) Ricoeur (2008) Merleau-Ponty (1999)

Table 8. Differential phenomenological positions.

In Greene's (1977) educational existentialist-phenomenological philosophy, she suggests that students should be encouraged to be "self-reflective" and be "wide awake" (Greene, 1977, p.448). Her thoughts align with the later work of Merleau-Ponty, with the significance of what awareness can mean with individuals locating themselves in an intersubjective reality, reaching backwards and forwards in time (Merleau-Ponty, 1999). This is not only a direction for education and a specific style of pedagogy in general, which Greene (1977) is suggesting, but I believe is also an indication of the methodological design of this proposed research study, which for me is to permit participants to reflect and curate their own understandings of personal transitions. Students from relatively disadvantaged backgrounds, pursuing a medical career, might be reflecting on their transitional journey by looking backwards, considering their current position and, through projection, looking forwards into their future as a doctor.

Methodology

Individual's story and the changed person: the perspective of the first person

The central aim of this inquiry is to capture the unique stories of medical students, as first-person accounts, which lends itself to an interpretivist paradigm to address the research problem. This paradigm ontologically assumes that realities are multiple, with cognition playing a central role in determining them, through a dynamic process constructing a person's reality, a process of knowing. Each student will possess a unique history in terms of culture, socio economic status and educational experience prior to accessing university, to name only a few of potential differences. From this point alone, it is easy to comprehend those experiences in different geographical locations, within different families and compulsory education institutions, will produce both different experiential landscapes and realities for individuals. To access medical students' recollections and current thoughts about their transitional journeys is the central aim of this inquiry, their unique realities for them.

What counts as knowledge, is the subjective understandings of each student's personal view of transition as a changing person, gained through appropriate techniques of investigation within the epistemological assumptions of the researcher, (Blaikie and Priest, 2017, p.8). In the case of this study, with a need for me as researcher, to gain relatively sensitive information about students' personal life stories and opinions about their progression over time, there will be a close interaction within the dialogue (Coe et al., 2017). They also suggest that through this potential close interactional relationship, the 'findings' are being created as the inquiry progresses, and as such the "distinction between ontology and epistemology dissolves" (Coe et al., 2017, p.18).

How the individual and the researcher see it

Beyond Greene's (1977) suggestion that students should be self-reflective and wide awake, the researcher likewise should be 'wide awake' and engage in critical reflection. To realise an in-depth comprehension of a person, the researcher must be able to empathise with the individual (Howell, 2013, p.158), yet simultaneously guard against steering individual students toward a predetermined outcome. I need to consider the relationship between power and knowledge through the form of reflexivity. In terms of my own positionality, I was socialised in a lower socio-economic family and geographical location, exited school without any qualifications, and was the first in my family to progress to higher education. Whilst these lived experiences for me, may potentially align with some experiences of the participants in the study, I will attempt to ensure the application of self-

examination, questioning and interpretations within the interaction with each participant, and I will have regard for the potential of power over the participants generally.

However, despite being aware of the need to pursue an inductive and ideographic approach in the study, to enhance the exposition of authentic stories of lived experiences, it is important to acknowledge the intersubjectivity of the process. Through dialogue, in the intended research process, there will be an interchange of conscious thoughts and feelings between two people facilitated by empathy, each student and myself. Intersubjectivity is described by Munroe (2019, p.2) as the "shared perception of reality between two or more individuals". The process and product of sharing experiences, knowledge, understandings, and expectations with others is a key feature of social constructionism and central to the further understanding of personal transitions of the medical students who consent to take part in the proposed study. The essential approach of my study is an interpretative one, the unique interpretation of certain medical students of their transitional lives, and my interpretation of the transitional process as they progress through their early years of medical education. In terms of the potential power dynamic between researcher and participants, mentioned above, I will subject my interpretation to scrutiny by sharing the transcript with the participants, after each recording of the interviews, and inviting them to inform me if it does not accord with their understanding of what was discussed.

Method

Having outlined the underpinning philosophy and methodology as the bases for designing the most appropriate method for this study, the following sections provide its detail:

The context of the research site

The intention of this study is to cover the features of the research site to provide a context of where WP entrants will study, along with the overall design framework for the inquiry. The proposed data collection and analysis techniques will be outlined, along with the acquisition of a required ethics permission. The study site is a research-intensive Russell Group University with generally high academic entry qualifications against which there has been a progressive 10-year increase in the percentage of WP entrants, except for years 2022-2023. There are a variety of WA routes to gain entry to the undergraduate medicine programme. These are the general university Access scheme, Interdisciplinary Science Foundation, and a foundation Gateway to Medicine programme, all of which use 'contextual admissions' criteria. The proportion of widening participation students, accessing the school of medicine through the contextualised approach over time, is indicated by the Table 8 below.

Year of WP Intake	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
%age of Total Intake	21	26	27	28	31	32	34	36	22	23

Table 9. School of Medicine increases in WP representation 2014 – 2023.

Whilst these increases in WA may suggest improvements in upward social mobility over the years, they do not capture the impact of the personal transitional experience for widening participation medical students generally. The impact could be significant students felt out of place in HE and did not develop a sense of belonging, for example. There is therefore a relative gap in our understanding of this group of medical students, which provides a space for new research. Consequently, this study will focus on WP students, and particularly those who are first in their family (FiF) to access HE.

Research design framework

Thomas (2016, p.23) defines case studies as "analyses of persons, events, decisions, periods, projects, policies, institutions or other systems" and is an in-depth inquiry. The design frame for this inquiry is a single case study, a North of England school of medicine, within which there will be eight individual cases, exploring the unique transitional experiences of students (Coe et al., 2017). Yin (2018) offers five key rationales for selecting a single case study design, critical, unusual, common, revelatory, or longitudinal. A revelatory case (Yin, 2018, pp.50-51) are situations where a phenomenon has not been previously investigated, which satisfies the position where this study sits. This qualitative inquiry aims to illuminate an understanding of the transitional process, capturing nuances in personal experiences at a granular level, the thoughts, and feelings of medical students' subjective realities (McConnell and Eva, 2015). The phenomenon 'experience of transition through the first two years of medical school', "is to be understood by those who have experience of it" (Bunniss and Kelly, 2010, p.360). Following my philosophical position, earlier in this chapter, the idiographic approach, focusing on eight individual (student) case studies exploring the phenomenon under study, will be employed to principally elicit lived experiences, thoughts and feelings of transition. Additionally, there may be some commonalities of experience which may emerge from comparisons of data across the individual participants' cases. However, my thinking is that any commonalities would not necessarily indicate similar life stories but potentially be helpful to theorise the nature of the transition process itself. A commonality which pre-existed was all students in the

study were first- in-their family to access university to study medicine, determined by the purposive sampling frame I imposed.

Sampling frame

The use of a purposive sample was justified because it allows a logical inference about the phenomenon of interest in the study by Bryman (2016), in this case illustrating transition experienced by medical students who are first-in-family to access higher education.

I was keen to explore experiences of transition from admission to the end of Year 2, the early years of medical education in the chosen university, temporally at three points in time. The rationale for choosing Years 1 and 2 was to span a period longitudinally, to capture transition and identity transformation in a trustworthy manner within the time constraints of a doctoral study. The proposed sampling frame for the two-year data collection period is provided below:

Academic Year 1	Academic Year 2
Participants: No. = 8	Participants: No. = 8
Time of interviews: Term 1 and Term 3	Time of interview: Term 3

Table 10. Sampling frame.

It was important that I evaluated sample size during the planning of a qualitative study. This I had done by using the Information Power model (Malterud et al., 2016, p.7) which ascertains that "the more information the sample holds, relevant for the actual study, the lower number of participants is needed". The guiding criteria for assessing the relative level of 'information power' are 'aim of the study', 'sample specificity', 'use of established theory', 'quality of dialogue', and 'analysis strategy' for gauging adequacy of sample size. The following table used the criteria in this model and qualified the sample size of 8 participants as being sufficient for this study.

Criteria	Indicative adequacy of information
Study Aim: [Narrow or Broad] A narrow aim offers sufficient information power and requires a smaller sample.	The aim to focus on the specific phenomenon of transition and the transformation of identity is sufficiently narrow.
Sample Specificity: [Dense or Sparse] A smaller sample is appropriate for participants holding highly specific, denser characteristics.	The characteristics of the participants are deemed to be dense, through being first in family to access university and specifically to pursue medicine.
Established Theory: [Applied or Not] Smaller samples can be adequate if there is a sufficient theoretical background.	Sufficient literature of widening participation, transition, self-perception, identity formation, and agency are applied to ground the study.
Quality of Dialogue: [Strong or Weak] A study with strong and clear communication between researcher and participants requires fewer participants.	The dialogue in all three interviews is planned to be sufficiently strong through a balanced interview technique, empowering participants to disclose personal thoughts and feelings.
Analysis Strategy: [Case or Cross-Case} A study with an in-depth analysis of narratives or discourse details from a few participants is adequate.	The single institutional case study, composing of eight individual personal cases is intended to achieve a richness and depth of analysis.

Table 11. Justification of sample size using Malterud's (2016) model for recruitment of participations.

A recruitment invitation for the research study was distributed to all Year 1 students, with approval received from the Gatekeeper of the undergraduate medical degree (Appendix 1). A video link (Appendix 2) was embedded within the Participant Information Sheet (Appendix 3), curated by a Year 5 student who was first in his family to access university, and reflected on his transitional experiences through the medical degree. I considered it useful to include the video link in the participant information sheet to remind potential participants that they were not the only FiF students to access and gain success in medicine, and thereby potentially mitigate feelings of impostor syndrome. Following expressions of interest to take part in the study, a Participant Consent Form was issued to prospective participants (Appendix 4). Both forms are referred to in the following section on ethics.

Subsequently, consenting participants were offered alternative dates and times to provide more freedom of choice and reduce any impact on their studies. I believed this was ethically appropriate to ensure that their continuing education was not unduly interrupted.

Proposed data collection

I previously established that the ontological assumptions are that the individual students will curate their own realities from their social world and 'worldview'. "Human beings view and interpret the world around them, as well as their place in it, from a variety of points of view or perspectives. We cannot avoid doing so" Blaikie and Priest (2017, p.15). In this context, the interpretivist / constructionist paradigm is the most appropriate to adopt, and epistemologically, the technique of investigation to align with this paradigm is to investigate the personal experiences of the participants. Interpretative paradigm data tend to be textual, for example the transcripts of the interviews. "In the interpretative paradigm, the emphasis is on demonstrating that a social scientific account is an authentic account of these actors' social lives" (Blaikie and Priest, 2017, p.38). Consequently, I remained sensitive to each participant during the online interviews and email contacts for the purpose of arranging interviews and transmitting the transcripts post interview.

Trialing data collection

Two methods of interviewing were considered, to ascertain the most effective way of uncovering lived experience, as indicated in the table below.

Interview methods	Rationale
1. Narrative inquiry	"How stories are told, focusing on how and why individuals choose specific language to represent something about themselves" (Coe et al., 2017, p.279).
2. Semi-structured interview	A semi-structured interview employs an interview schedule with a series of questions, but the interviewer has latitude to vary the sequence and ask additional questions in response to significant responses by participants, in development of the story (Bryman, 2016, p.201).

Table 12. Potential interview methods.

I decided to use elements of both methods to ensure a comprehensive interview technique, essentially a semi-structured approach to facilitate open responses from the participants and a focus on their narratives to consider why they use particular words or concepts to develop their story. This will be discussed in more detail below.

A pilot interview was arranged with the Year 5 student, referred to in the recruitment section above, to ascertain which of the interview methods elicited responses in the field of transition and identity transformation, in relation to personal recollections of transition. Despite developing a brief interview schedule, I left sufficient freedom for the participant to follow their own lead and direction. I was keen to develop rapport with the participants through creating an informal atmosphere where participants felt comfortable to discuss personal experiences. Essentially, a conversational style. I placed considerable power in the hands of the students to start unravelling the story of their earlier lives. As a means of increasing the 'trustworthiness' of the data, I decided that following the audio-recording and transcription of each interview, a copy of the interview transcription would be emailed to the participant for reflection, and the possibility for following up any aspects of their account, in the subsequent interview(s). The purpose of this strategy is two-fold, firstly to enhance the continuity of the storying, and secondly to facilitate reflection and reflexivity in the participants. I also believe that this will indicate an aspect of 'member checking', as indicated by Varpio et al (2017), where, "participants may be asked to review their transcripts to consider if their words match intended meanings," (2017, p. 46).

The pilot interview proved to be both informative and helpful in deciding the final format and conduct of the intended interviews. What I specifically learned from this trial interview was, the phrasing of questions to ensure they were relatable to previous or current experiences, providing sufficient thinking time for reflection, and using participant responses to trigger additional questions to extend the narrative of the storyline. The result was to create a set of stimulus questions for each of the three interviews to provide a broad guide to the conversations but equally so, to focus on the narrative and meanings in the choice of language being used. Interviews, at three points in time, across the two early years of medical education are indicated in the table below.

Interview	**Timing of interviews**	**Areas of questions / discourse**
1	Year 1 / Term 1	*The back story*: Early school / family life. Applying for and accessing medicine. Settling in / sense of belonging

2	Year 1 / Term 3	Reflections on the first year, interactions, progress, and impact of Covid-19 / 'lock down' and online learning.
3	Year 2 / Term 3	Transition to Year 2, Impact of learning on campus, clinical placements increasing interaction with peers and identity transformations.

Table 13. Semi-structured interview schedule.

The potential areas of stimulus and questions for Interview 3 are provided in Appendix 8 as an example of the suite of questions. I believe that using them in combination is ideally suited to this inquiry because of the requirement to elicit the student's personal understandings of their own transition and development of identities. I use 'identities', and not merely a single identity, advisedly to imply that we possess multiple identities, one aspect of which, for example, may be 'professional identity'.

Proposed narrative analysis

Qualitative analysis in the form of narrative inquiry attempts to retain the integrity of the phenomenon by keeping close to the language and meanings of the participants. This is crucial to this inquiry, bearing in mind that it is their story, their lived experience, and the essence and meaning of their transition which needs to be explored. Providing opportunities, through semi-structured interviews (King et al., 2019) for individuals to tell stories of their lives, permits them to make sense of who they are (Wortham, 2001) and, in the context of this research, who they are, and who they are becoming; the truth as they see it. As Wortham (2001, p.xi) commented, "Telling a story about oneself can sometimes transform that self", where expressions of personal transformation might be found. McAdams (1993) also suggests that we construct identity in a similar way to how a storyteller composes a story.

I believe that the curation of identity, of being and becoming, is framed within the transitional process of progressing into university, as FiF to access higher education, and through these early years of medical education. Experiences which underpin the continuing evolution of identity and perceptions of becoming, are context bound and produce situated meanings, which the narrator assigns to a point in time (Gee, 2014). This suggests that being and becoming requires the participation of others to create a sense of 'fitting in', or of belonging. Additionally, Monrouxe and Rees (2015) have added to the social constructionist approach, in the research of identity in healthcare education, by suggesting that identities are, "constructed through talk and interaction,

rather than being constructed within an individual's cognition" (Monrouxe and Rees, 2015, p.133). Emphasising the relevance of social context and social cognitive theoretical position, Torre and Durning (2015) suggest that cognition is situated and "thinking, learning and performance emerges from relationships with others" (peers, patients and tutors) and with properties of the environment.

In the context of this inquiry, I will refer to the feelings of academic or social connections (amongst others) to emphasise the social aspect of the transitional process. Yet as McAdams (1993) argues, that although there are so many different coherent lives possible, it would be impossible to create a universal typology to represent everyone, hence the need for an ideographic focus. However, simultaneously there will be an opportunity to interpret the rich date to facilitate theorisation of transition which potentially has implications for all students. Indeed, O'Shea (2016) remarks that using Yosso's (2005) Community Cultural Wealth Framework, individuals can be viewed as drawing on capital reserves in their transition to, and through, higher education. This sort of analysis might build on a variety of personally meaning capitals (or assets) which resonate with students' self-efficacy beliefs, and determination for lifelong learning, expressed through their storytelling and transformative identities.

Sharp et al. (2019) suggest that narrative inquiry methods can offer much, for health and social research, to reveal complex nuances of human experience and understandings of how individuals make sense of their lives. Procedures of narrative analysis reveal a constructed story of an individual participant, and paradigmatic analysis uses both inductive and deductive procedures to identify any common or contrasting themes between different stories. Whilst I am intending to highlight and value the importance of uniqueness of students' lived experiences, the data may simultaneously indicate some common experiences of widening participation. These two methods of analysis might be used independently or together. Reflections of past experiences, and current thinking about academic learning and becoming a doctor, through storytelling, might induce awareness of personal transitions through life and transformations of identity. Gergen (1994, p.186) suggests that stories become a "vehicle through which the reality of life is made manifest … we live by stories both in the telling and the realising of the self".

Polkinghorne (1995) distinguished two types of narrative inquiry and consequentially two types of narrative analysis:

1. Analysis where understanding is expressed in story form with a 'plot', and
2. 'Paradigmatic analysis' encompassing inductive discovery in the form of categories or themes within the data.

I intend to employ the complementary use of both approaches to the data in order develop individual case studies for each participant and secondly to consider any potential themes across all eight stories. Effectively, this will involve an initial ideographic approach, followed by a more nomothetic approach. Essentially, this will recognise and acknowledge diversity and individuality, but also possible similarities of the transitional process. Polkinghorne (1995) suggested some guiding criteria for the construction of narratives, including:

1.	The cultural and social context of the story
2.	Any relationships between participant and other significant people in their lives
3.	Any goals, choices, interests, and actions which impact on their meanings and vision of the world
4.	Any historical experiences and events that have influenced the participant's life story
5.	Recognition of timeline of the story, beginning, middle and end
6.	A meaningful explanation of participant's experiences and actions in a credible and understandable way

Table 14. Polkinghorne's (1995) **guiding criteria for construction of narratives.**

I intend to use these as overall, generic guidelines for conducting the interviews, and in the subsequent analysis of the data. As an example of criteria 4 and 5, asking each participant at the beginning of the first interview, to think about their 'back story' and recount experiences in their primary or secondary school life, starting the story at a point of their choosing. My rationale for this is to give complete ownership to the student in their recollections of learning, relationships, links with family, and a potential essence of transition over time. This facilitated Polkinghorne's first and second criteria, and additionally, to empower the participant to own the story on which they are about to embark. Prior to undertaking interviews 2 and 3, I will email an interview transcript of the previous interview, to each participant, inviting them to consider an aspect from the previous interview which they found particularly pertinent and would wish to discuss in more depth. The justification for this was to facilitate life stories in a temporal framework, focusing on Polkinghorne's fifth criterion. Polkinghorne's sixth criterion will be facilitated in two specific ways, firstly by the style of the interview process, as an informal conversation, encouraging deep reflection of lived experiences, and secondly by my need to focus on participants' meanings and my meaning of their accounts.

Positionality / reflexivity

The reflexive character of qualitative research means that researchers will inevitably inject something of themselves into the process and subsequently the outcomes of the research (Blaikie and Priest, 2017). I acknowledge the assumption of the potential value-laden context of a qualitative inquiry and potential for biases. Berger (2015) highlights the potential for bias in qualitative work where the researcher has personal experience related to it. From my perspective, my view of the world stems from my own biography and professional experiences. From my own positionality, I am firmly grounded in both social justice and believe that given opportunities and support, disadvantaged learners who develop agency will make progress, sometimes in the face of considerable adversities. The concept of agency is used in a variety of theories, which were outlined in Chapter 4, Theoretical Framework, and in the context of my theorisation I am using it to convey the quality and capacity for self-directed learning and progression in one's life world. In addition to this, we might conceive of the possession of Yosso's (2005) 'aspirational, 'resistant' and 'navigational capitals. In my career, I have been fortunate to work with learners who had not performed well in post – 16 or post – 18 examinations in school but proceeded to excel within a 'second chance' situation, and for some of whom progressed to study in HE and embark on professional careers.

With qualitative interviewing we are in some way, actively shaping how interactions will unfold, and are perhaps unavoidably co-creating or co-constructing the outcomes in train. Finlay and Gough (2003) indicate how reflexivity locates researchers in qualitative research and implicates them in the entire process of knowledge production. Not only does reflexivity require critical self-reflection, incorporating an awareness of their social background and personal assumptions, it challenges research tradition and is challenging to apply. I believe that it may be considered that qualitative researchers require a certain level of meta-awareness. In practice this would consider moving beyond the 'inward approach' to reflexivity, that is merely considering the position of one's own background, biases, and assumptions, to an outward look at interaction, discourse, and shared meanings with the participants. In practice, although recognising that some co-construction may be in evidence, a hermeneutic phenomenological approach supports an interviewee to have an element of 'free-will' to structure their own narrative account of their ongoing story (Van Manen, 2016), and any potential 'turning points' in their transition.

A possible opening question to empower the interviewee to commence their story in Interview 1, is to be, 'Could you give me the back story of your life, within your family, primary or secondary school, or wherever you would like to start your journey, which would eventually lead you to study medicine'.

Ethics and ethical approval MREC 20-028 [02.02.2021]

Based on this study being of a sensitive nature, with participants potentially disclosing personal thoughts, experiences, and values, it is incumbent on me as the sole researcher, to conduct the entire study in a morally acceptable fashion. This involves not only integrity on my part, but also consideration of aspects of consent, confidentiality, potential role conflict and ensuing challenges in the dissemination of findings (Reid et al., 2018, p.70). In recognition of my duty of care, I will pursue my moral obligation to both honesty and integrity in terms of the procedural ethics of gaining approval and processual ethics during the entire course of the inquiry, complying with the university ethics approval and the (HM Government, 2018). The information for participants included options to stop during the interviews, withdraw from the study, and to provide sources of support, should participants wish to access them.

The intention is to ensure a position of duty and obligation in pursuit of the inquiry from gaining approval and finally embarking on the study, through to reporting the outcome. For judgements to be made about the appropriateness of ethical intentions and actions, it is recognised the unintentional and unexpected situations may occur during the study which need to be addressed. If students disclosed something which had safeguarding or patient safety implications, I would need to act on this, as indicated in my ethics application. To ensure compliance, my application stated that, 'if students disclose unprofessional behaviour or express poor practice, they will be informed that the matter would be escalated to academic supervisory teams'. Part of the reason for previously stating my positionality and the ongoing requirement for reflexivity, is to take account of issues which may need to be resolved ethically and responsibly at any moment in time. Examples of a situation, where a participant may disclose some aspects of their thoughts, feelings and lived experiences which may identify them, so during the reporting of findings stage, such information may be excluded. Another example might be a disclosure of a mental health problem, which likewise may need to be addressed.

I asked participants to choose a pseudonym known only to them and me the researcher, which will be used in the transcripts and subsequent references made in the findings. Indeed King et al. (2019, p.46) recommend "…that wherever possible pseudonyms should be assigned as part of the transcription process… so researchers are less likely to find themselves talking about participants by their real names". Additionally, I invited the participants to choose their own pseudonym at the end of Interview 1, not only so that it would be in place immediately when I forwarded the first completed transcript, but also for each participant to recognise their personal input to the research

in the final thesis (should they wish to read it). Anonymity and confidentiality within the data is crucial in qualitative research, in that during the interviews it may be appropriate to divert from a very sensitive topic which they disclose, and refrain from recording aspects of their biographical data which could be potentially identifiable (King et al., 2019, p.47). All potential participants will be unknown to the researcher and will voluntarily consent to take part in the study. They are to receive a small token in the form of a store voucher at the end of Year 1 and Year 2. However, participants will not be made aware of these tokens, as an expression of gratitude, prior to consenting to take part, to avoid any perceptions of coercion (King et al., 2019, p.44).

Student reflections on the personal value of the interview process

During the second and third interviews it emerged, independently by all students, that they considerably valued the informal conversations across the study allowing them to reflect deeply on transition through Years 1 and 2 of the undergraduate programme. Following on from their lead, I decided to initiate a supplementary piece of data collection to capture their thoughts and feelings through reflexivity.

I applied for an amendment to my original Ethics approval, for an extension of data collection, which was granted in June 2022, indicated in Appendix 6. This was followed by a request to the participants to consider their thoughts on the use of the informal dialogues as a means of exploring their transitional journeys. The request emailed to the participants is indicated in Appendix 7.

75% of the participants responded to the request with their considered reflections and the findings for the additional supplementary data are provided in Chapter 7 - Findings Part 2. The remaining participants were unable to respond with being out of the UK during the summer holiday between Year 2 and Year 3 of the undergraduate programme.

Summary

In contextualising the site of the research study, the process of the inquiry has been detailed to provide the necessary elements of the method. The design and sampling frameworks, and recruitment procedures, are outlined should similar studies wish to be replicated in other contexts. Proposed data collection and analysis, based on the chosen methodological stance, is sufficiently stated to underpin subsequent trustworthy findings, Chapters 6 and 7, and discussion of the overall inquiry, Chapter 8.

6. FINDINGS PART 1

Introduction

In the previous chapter on 'method' I referred to my positionality and reflexivity, and the possibility that qualitative researchers may inevitably inject something of themselves into the process. It was important to me, in the analysis of the data, to maximise a trustworthiness of my perceived findings. This was not only in respecting the essence of the medical students' stories being told, my respect for the participants' truth, but was also crucial, in my analytical approach and reflective decisions, to provide clarity in how and why I chose to focus on specific elements of the personal narratives. Words or phrases are selected by participants to express their feelings, meanings, or recollection of events in their lives, as their lived experiences, and how previous events might impact on ongoing relationships and academic progress. Elaboration of their narratives through our ongoing dialogue further refined participants' responses which attuned me to their specific thoughts on identity transformation and personal accounts of ongoing transitions.

Additionally, current perceived capacity to cope with the curriculum, and in some cases their hopes and intentions for the future which may be expressed authentically were sought. I have assumed that participants choose words to story their lived experiences which best fit their meanings, thereby providing authenticity and accuracy of their stories of transition over time. To facilitate an ease and willingness to express aspects of their essence in a relatively free and unfettered way, I conducted the interviews as continuous informal conversations, ensuring that disclosures were given freely.

Hence, their recollections might be from much earlier phases in their lives, or more recent ones. Reflexively, I constantly needed to be conscious of why my focus landed on a specific part of a narrative. It would be possible for a researcher to selectively choose one part of a story, at the expense of other possible elements, which highlights a potential issue in socially constructed worlds. Recognising that both constructivist and constructionist ontologies believe the existence of multiple realities, the former's epistemology (constructivist) considers the individual constructs their own knowledge which is represented cognitively. Whereas the constructionist epistemology considers reality being constructed through interactions between the individuals and their social worlds, which "are deeply entangled through dialogue" Varpio et al. (2017, p.42). This compounding nature of the qualitative research process, with respect to each student perceiving the truth of their worlds, along with my interpretation of their stories of transition, effectively my perceived truth, requires consideration within the analytical process and decisions to represent narratives and collate findings.

In managing this issue, I opted for a design which looks at the interview from two angles, by using two methods of narrative analysis. This is not a form of methodological triangulation but a way to view the data through more than one lens, so there is less risk of one lens being driven by my experiences or expectations.

The first part focuses on the students' idiographic narratives or their stories of transition. The second part reframes these narratives into themes reflecting my interpretation. These analytical methods align with Polkinghorne (1995) and Baskerville et al. (2016) with two types of narrative inquiry, and consequently two types of narrative analysis. The initial one is ideographic where understanding is expressed in story form, which is illuminated in the remainder of this chapter. The second type, outlined in the next chapter (7) is 'paradigmatic analysis', which encompasses an inductive discovery of themes within the data.

In addition to this, it is worthy of note that beyond the application these two analytical methods, I was sensitised to the distinction between monologic and dialogic in the construction of personal narratives (Wortham, 2001, p.145). Despite my invitation in the first interview to 'tell their backstory', I did not position the student as monologically constructing an autobiography of their lifeworld but dialogically partially constructing the self through the medium of our conversations.

Each transcript, from the three interviews were first analysed individually, to highlight biographical accounts relating to family background, primary and secondary school experiences, motivational inclinations and application to learning. Examples of analytical commentaries and notes are provided in Tables 14 and 15 in the following pages.

Part 1: Understandings of the eight case studies

Each participant's story, narrated through three interviews, is constructed and disclosed within the context of their personal background and lived experiences prior to entry, and the two early years of medical education. On my part, I chose to quote their words and use them to help me interpret meaning from the data and, as the analysis progressed, used theme labels that have meaning to me, given my research question.

To contextualise backgrounds and the participants' earlier social experiences, within the eight case studies, the table below briefly profiles biographical data to set against their curated narratives. Liz for example, might be regarded as a case study of a working-class mature student, with Ziya, a case

study of a lower working-class student of Indian descent, who accessed a private school for her secondary education.

Participant Self-selected Pseudonym	**Gender**	**Family Background**	**School Experiences**	**Pre Medical Education Experiences**	
Liz Mature student	F	Initially worked in family-owned (semi-skilled) company. Self-proclaimed as 'working class'.	Changed to Sciences from Arts	Access course.	
Theo	F	Parents from working class backgrounds. One parent on benefits. Raised in a book / learning culture.	Age 11 gained scholarship bursary to private school. Additionally gained an EPQ [independent research project]		Support from a teacher, who had been a pathologist, was working-class and supported WP students to access medicine.
Olivia	F	Mother administrator in optometry, encouraged her to consider medicine. Father discouraged her /said it was too hard, no work / life balance.	No thoughts of medicine until unexpectedly receiving very good GCSE results. Decided to take A level sciences / Maths / Art. Prefers creativity.	Volunteering / caring in the community. Work experience in hospital	During A levels tutored pupils at GCSE level. Raised funds for African trip / building a classroom and tutoring children in orphanage. Completed many MOOC courses.
Sarah Mature student	F	Single-parent family, mother in administrative work. Grandmother retired, No one in family influencing decision to study medicine.	Secondary school in deprived city area. followed by science, maths and Psychology A levels. Poor results required that chemistry and maths were dropped, and A level Law gained in the 2nd Year.	After GCSE's attended two WP medical summer schools. Accessed BioMed undergraduate course with possible transfer to Medicine after Year 1.	Friend of girl whose father was doctor. Shadowed him, helped her with UCAT and application process. As a graduate, having to work part time to pay fees.

Ziya	F	Parents migrated from Indian sub-continent, unemployed, and do not speak English. One of two girls. By own admission – a deprived background. Perceives self as lower class. Indian descent.	Very shy in school, speaking very little. Mentored by a teacher and a tutor, who triggered engagement in learning, and encouraged her to entrance exam for private school, where 16% of students from minority backgrounds.	Parents of friends at private school in medical profession and vicarious contacts to help with understanding medicine. Speaks four languages including English.	Work experience in hospice and care home. Openly recognised as a role model for other girls in family.
Aura	F	Perceives self as working-class. Parents business owners and did not progress to HE They wished Aura to go to university and not into the family business. Living in deprived area. One brother. Indian descent.	Gained a bursary to a private school. Pursued sciences at GCSE and A levels. No support for HE applications from School. A strong peer group shared online information e.g. BMAT and UKCAT	When A level Biology wasn't progressing sufficiently well, Father researched Ex UK medical schools, as possible safety net. Accessed Foundation degree in Clinical Sciences.	Tutoring students from WP backgrounds for In2MedSchool (2024) national organisation, to help with application system. Good mental health support in private school. Giving back to WP evolutionary process.
Loki	F	Aunt was a nurse - inspiration to be in health care. Also interested in a particular aspect of medicine due to losing two siblings. Intrigued by midwifery and father suggested she might do gynaecology. Mother impressed by dedication and inter-	Transferred to 6th form college, poor teaching / lack of feedback in some A level subjects. Additionally completed an EPQ. Self-professed independent learner / parents very supportive / prioritise her education.	Not attained sufficient grades to access Medicine, so accessed clinical sciences foundation year.	At 16 volunteered in care home, working with end-of-life care. Impact of Covid-19, was a more difficult journey.

		relational skills of doctors. Indian descent.			
Ellie	F	Mother, NHS administrator. Very supportive.	Attended very good primary and secondary schools. (triple sciences). Transferred to 6th Form College Biology, Maths. Chemistry, GP Work experience.	Self-perceived independent learner.	Attended two medical access schemes. Gained support for application process. Impact of Covid and facilitated pre-formed relationships with medical school peers.

Table 15. Participants' profiles of background and experiences.

The sample is all female, five are white students and three students are of Indian ethnicity, and additionally, three of the eight participants accessed private secondary education, by means of a bursary scholarship, as none of their parents could afford private education. This was the volunteer sample obtained through an open recruitment process to all First-year students who identified as FiF. Reference to these backgrounds and idiographic experience profiles were used to juxtapose the participants life world experiences and the meaning making in their narrative accounts. However, to avoid my interpretations being unduly deductive, from possible assumptions emanating from the individual contextualised backgrounds, revealed during the first interview, I adopted a particular strategy for analysing narratives in transcripts. I reconfigured the original transcripts for all three interviews, to landscape orientation in a tabular format, with the participant narrative on the left and right-hand column for my reflexive responses.

An example of this analytical strategy is provided for Sarah's first interview, where she recounts her decision to opt for an additional experience facilitated by her school during her final GCSE year. The event explored access to medical school, and is captured in the transcript extract below, along with my provisional responses.

Participant Narrative	Reflexive Response
"… I just saw that there was a work experience class going on at school or my school advertising something for getting into medical school. I was a mediocre student …… in the top set for maths and English … the school I went to was in quite a deprived area of the city that I lived … so it wasn't … the bar wasn't set too high. So, I went to this summer school and decided I quite liked the idea of it. It was the	Self-concept / identity of being mediocre student. Perception of 'average' might belie capacities for learning or agency to learn. Location of school and its culture of low performance in supporting A

XXXX Medical School um, and it was a widening participation scheme to get people into medicine. I decided on A level choices … chemistry, biology, maths and psychology. I think in the history of the 6th Form they'd only progressed one student into medical school. So, I don't think, they didn't even realise at the time that you need to do chemistry and biology to get into medical school They didn't even know what the UCAT and BMAT tests were for admission."	level students seem apparent at this stage of Sarah's account. Supporting students to access medicine seems quite impoverished. Living in 'deprived area' and attending a school with limited progression routes to HE indicative of WP criteria.

Table 16. Example of first stage narrative analysis.

Over the two years of the longitudinal study and three substantial interviews with Sarah I was able to build her individual case study in the context of me being a 'bricoleur' (outlined in Chapter 4), combining elements of her personal story in conjunction with theoretical concepts, reviewed literature and notions from my extensive professional career in education working with underrepresented learners. All these aspects sensitised me to formulating paradigmatic codes within each individual case study and subsequently across all eight case studies. To exemplify the use of this strategy in Ellie's transcript of the first interview I primarily focused on the essence of specific narratives (words or phrases), in advance of reminding myself of her detailed background, and made a brief response as an initial comment. Examples from the transcript of Ellie's first interview are:

a) Having spent considerable time visiting an elderly relative with a terminal illness: "… that was kind of the first point where I started thinking. OK, like maybe I could be a doctor. Maybe I could do something like this"
   My response was 'Liminal' / 'transitional thinking' towards a career in medicine.
b) When her relative passed away: "I kind of started doubting myself."
   My response was 'Identity' potential 'impostor syndrome'
c) "… so, I spent a lot of time …being like. Well, maybe I should do this, maybe I should do that, you know?
   My response was 'indecision' 'not sure of future', no specific career plan.

Similarly, examples from Loki's transcript of the first interview are:

a) "I think from quite a young age I knew I wanted to do like within health care ... My aunty was a nurse"
   My response was 'early interest in healthcare' and 'potential role model in family', maybe an aspect of social capital.

b) "…. two siblings ... unfortunately passed away … had a genetic condition."
My response was 'prompted by difficult medically related experiences in family'.

c) "… like when you do GCSE and A levels and learning about genetics, and I think like that was probably the one topic I was always looking forward to."
My response was. 'Impact of intrinsic motivation for learning', maybe an aspect of cultural capital.

In this context I was using social and cultural capital in the Bourdieusian sense that 'social capital' is linked to an influence from a specific person who you know and cultural capital principally as knowledge coming through the family.

I regarded these initial responses as markers, or "contextualism cues" Wortham (2001, p.36) which provide "emergence" and "coherence of subsequent utterances" (2001, p. 41) which I could return to after further data analysis and interpretation. The intention throughout the analysis, was to remain close to the language and meanings of the participants, in order to retain the integrity of the phenomenon (personal transition) and students making sense of who they are (Wortham, 2001, p.157). Wortham emphasised that the process of curating the self involves both past and current selves (2001, p.137) and to facilitate the participants' capacity to think about the self in the first interview. I began the conversation by inviting them to tell me about their early experiences in the family, school and the community, as a means of empowering them, for me to hear their voice, and provide a biographical account of their early lived experiences prior to university. I emphasised that they could commence their story exactly where they wished. The story was theirs, and I wanted them to use it as a means of owning the auto-biographical story as a proxy for their personal transition over time. The latter part of the first interview principally focused on their transition into to medical school and early experiences of Year 1. Subsequent interviews (2 and 3), focused principally on transition through the first two years of medical school.

In summary, the stories curated, over the longitudinal study, are about past lives and the journey into medical school, the initial experiences of the first year, including the impact of Covid-19, and the experiences of the second undergraduate year (with the relative normality of an open university campus and medical placements in both primary and secondary care).

To ensure interpretive relevance in my understanding of their account, if I was unsure of their meaning, I would invite them to say a little more about a particular point or their specific understanding of a particular word or phrase used. At the end of each interview, I indicated that when the recording was transcribed, I would email the transcription and invite them to respond by

reading our conversation and informing me of any perceived misrepresentation on my part. My justification for the approach was that the dialogic process was perceived by me as a learning tool to support thinking about past and current experiences, and any perceptions of transformational identities in the making. During the data collection phase, to capture a deep understanding of the evolving stories, I adopted a conversational style of interview, to maximise gains in revelatory narratives and a level of comfort for all the participants.

Additionally, having agreed a date and time for the second and third interviews with each participant, I emailed them to ask if they could focus on some aspect in the previous interview that they would like to reflect on further, and offer as a starting point to our next discussion. The purpose of this was to continue empowering the students to own their story, with the potential impact on their continual transition and any perceived identity transformations. The intention was to reduce the level of bias in this qualitative inquiry and increase the possibility for a richness in the findings being created through an ideographic approach, with me as researcher, being carefully attuned to participant voices. The apparent relative ease with which all the students engaged with the interview process is outlined in the reflective responses outlined in chapter 8; revealing how the participants valued the informal interview style which facilitated their self-curation of a personal transition.

The participants were interviewed at three separate data points over two academic years, and following the data collection period I read the transcripts multiple times to familiarise myself with the data and consider how best to make sense of it, eventually drawing on the approach identified by Polkinghorne (1995), the method previously detailed. The other type of analysis, underpinning the approach adopted in Chapter 7 of the findings, the themes, is a paradigmatic analysis which sensitises the researcher to appreciating conceptual or theoretical knowledge. This appreciation is not to deductively use theoretical categories to fit the data into, but to support or extend concepts in the investigation of the participants' experiences and meanings they attach to them, which was detailed in Chapter 5, the section on proposed narrative analysis. The interconnected analytical procedures distinguished by Polkinghorne (1995) indicates two types of narrative inquiry with two subsequent types of narrative analysis. The first type is where understanding is expressed in story form (possibly with a 'plot'), retaining situational complexity, where 'being' is explored, along with the attached motivations and emotions. The essence of this type of **'**inductive method**'** is where questions are asked of the data, e.g. 'why is this important', 'how did this experience make the student feel', or 'how did they respond'? (Corbin and Strauss, 2014). This analytical approach formed the basis of the findings within this chapter.

The findings in this chapter, focus on the eight single case studies to appreciate the unique (ideographic) experiences of individual students and the transitions they curate through their own personal stories and deep iterative reflections. To repeat Wortham (2001, p.xi), "Telling a story about oneself can sometimes transform that self", where expressions of personal transformation might be found. This curation of identity, of being and becoming, is framed within the transitional process of progressing into university, as FiF to access higher education, and through the two early years of medical education. Experiences which underpin the continuing evolution of identity and perceptions of becoming, are context bound and produce situated meanings which the narrator often assigns to a point in time (Gee, 2014). The analysis has been formulated through the exploration of students' iterative reflections longitudinally across the entire study; reflections representing a continuous personal transition and unending transformation of identities. Interpretive understandings are formulated from individuals recognising and making meaning of the events and actions that are part of their existence.

This narrative inquiry has sought to explore the uniqueness of individuals' autobiographical narratives, which might be built through the means of a variety of personally meaningful capitals or assets, resonating with students' self-efficacy beliefs, and lifelong learning, and expressed through their storytelling and transformative identities. My analysis is that these personally meaningful capitals or assets, which are explored through the themes in the following chapter, support the students in their transitions.

Note:

1. The use of N1, N2, or N3 following a participant's quotation, indicates where the narrative [N] is drawn from, either the first, second or third interview, across Years 1 and 2 of the undergraduate programmes in medicine.

Case 1 - Liz:

Liz's story expresses a varied and circuitous journey to medical school, a long way from two years of working for the family company, not knowing anyone who had been to university, nor considering medicine as a career during the early stages of her life. There have been changes in thinking and direction over time, as she has searched for opportunities, to try something new, and reflect on her life as she progresses. Liz has clearly demonstrated she is a self-directed learner throughout her educational career, despite her family not having directly encultured her with capital, in Bourdieusian (1973) terms or familial capital as suggested by Yosso (2005). Her long-term partner, qualified to post graduate level and whose family are accomplished educationally, has provided Liz with a level of

extrinsic motivation and role-modelling. Her parents engendered a work ethic in her during the protracted time of her working in the family company, which I believe has provided the basis for an intrinsic motivation for self-directed study.

Through continual reflection, Liz demonstrated she is a reflexive self-narrator. She suggests that she has agency, with a feeling of control over her behaviour and the consequences of her decisions and actions. I would suggest that she has demonstrable evidence to indicate a form of resistance capital, suggested by Yosso (2005), as a disposition to oppose subordination at times when a suggested educational direction does not align with her wishes, for example, at sixth form college, wanting to change from the study of music to sciences.

> "I was quite defiant …. But I don't regret it …. I never would have pushed the boundaries that I need to push to get where I am if that makes sense." [N1]

This capacity is mirrored by her expression of 'aspirational capital' (Yosso, 2005; O'Shea, 2016) in her consideration of other possibilities beyond current situations. Latterly embarking on a foundation level course, prior to transferring to the medical degree, is an example of these mindsets and a determination to succeed in whichever direction Liz wished to move. She showed an interest in continual professional learning, by deciding, during the latter stage of Year 2, to intercalate in clinical anatomy prior to commencing Year 3 of the MBChB.

> "…I got the offer last week; I've just been accepted on clinical anatomy. I think ideally, I would have done something a bit later, but I'm not very good with big changes, so I think it would be easier for me to have academic and clinical very separated." [N3]

A particularly pertinent aspect of Liz's account of her personal story and her ongoing reflections around her perceived identity, is that of belonging to a working-class family, 'being working-class', and feelings in perceptual changes of 'becoming middle class'. These perceptions seem to be partly formed by dialogues with her partner around socio-economic-status, and their potential future salaries, which might be understood within the context of social mobility. An aspect of these changes in perception is possible cultural conflict as Liz believes that she and her family are according to Liz, living in 'two different worlds', although she feels that her parents are still emotionally supportive of her work and endeavours. This element of her transition is perhaps an aspect of transgenerational change in the personal perceptions of social class, and disjunctions which may be exposed. Indicating discussions she has with her long-term partner, Liz revealed,

> "… we have conversations about all sorts of things. Whereas, if you used to mention one of our conversations [with her partner] to my family, they'd be like, 'oh I didn't see that, but did you watch the England game last week?" "And you know there's a huge divide there." [N2]

In one or two instances, there appeared to be some aspects of changes to accent, dialect or language used to increase solidarity when she returns to the home community. Despite this, Liz hasn't discarded her social roots on her educational path to medicine and is contributing by 'giving back' and supporting other widening access participants from disadvantaged backgrounds, which augurs well for perpetuating WP and the WA movement.

Case 2 - Theo:

Theo comes from a working-class family, with one parent living on social benefits, neither parent had progressed to higher education, however, both had been in an occupation which valued reading and education. This familial capital enthused Theo and developed an intrinsic motivation and agency as an early self-directed learner. The early support for learning and a good education directed her towards applying for a scholarship, gaining a bursary at a private school.

> "… my parents are both very enthused and very sort of book learning … I was working very hard, and I think that's the reason they sort of thought. 'Why not apply for a scholarship'? So, I sat the exam, managed to get a scholarship into a private school" "And I think that, coupled with sort of my parents raising me in this culture of learning …… was what set me on this trajectory toward medicine, I suppose." [N1]

> "I've always been an independent learner [and] coming to medicine was me doing my own research into it." "I just picked up the habit of learning to do work independently …… in college we did the EPQ, which is an independent learning project." [N1]

As a self-confessed independent learner Theo believed she had transitioned quite smoothly into university. With some of her peers in secondary education having parents who were doctors, some social and cultural capital was gained through conversations with these members of the medical profession, in addition to support from a particular teacher who had been a pathologist in their early career, prior to qualifying as a teacher. Theo also organised her own work experience independently.

Despite the many restrictions to meeting face to face in the first year of medical school, due to Covid-19 lockdown, Theo made much effort to join student's sporting or educational groups and kept in touch with friends online. This capacity to make connections and instigate positive changes demonstrates a continued trajectory underpinned by her self-sufficiency and agentic behaviour,

coupled with a well-developed level of confidence. I believe that high intrinsic motivation to make instrumental decisions for progress is a defining feature of learners, whose self-determination pays dividends over time; such I think, is the case with Theo.

Theo's narrative, on several occasions indicates her capacity for deep reflection, particularly about her clinical exposure and its impact on her transition, where she implicitly evaluates her self-efficacy beliefs.

> "I think it is something I reflect on…you kind of have to do it in the medical field because you need to keep track of how you're improving and how you're changing to be a competent medical professional." [N3]

She explicitly recognises the requirement to be a reflective practitioner when qualified but equally understands the advantage of reflection for a 'smooth' transition through medical education. Theo's agency and introspection, marked by her levels of confidence and competence, seem to underpin a student who is progressing smoothly, and is aware of her educational trajectory.

Case 3 - Olivia:

Although Olivia perceived herself as an academic at school and worked hard in her GCSE subjects, she wasn't sure of career directions and certainly had no allusions about medicine. However, she had undertaken a great deal of volunteering, working in a care home and self-financing herself for a 4-week excursion to an African State, teaching children in an orphanage and manual work building a classroom. The trigger to giving serious thought about a career in medicine, was receiving excellent GCSE results which prompted her to select A level subjects which could gain her access to medical school. Discussions with her parents about potential careers and reflecting on her capability, demonstrated by her examination results, indicated the contribution of 'familial capital' (Yosso, 2005) and the effects of her 'self-efficacy beliefs' on identity change, the 'becoming' of a more focused Olivia. It is worth noting that both her parents were not equally supportive of her pursuing medicine as a career. Her mother said she had regretted not doing medicine, which made Olivia think,

> "Well … maybe medicine!" Though her father was always saying,
>
> "No, you shouldn't do medicine, it's too hard" … "It'll be too tough" … "The work life balance is hard." [N1]

From the beginning of her A level programme, having gained exceptional GCSE results, it seemed as though she was demonstrating what I view as self-styled aspirational capital (Yosso, 2005), which began to underpin her transitional journey. Self-determined learning and 'learning by teaching'

seems to have evolved as a central feature of Olivia's mode of operating. Seeking out and completing many 'Future Learn', Massive Open Online Courses (MOOCS), or teaching younger students during her A level studies and working collaboratively with undergraduate peers are examples of her educational approach. There are regular examples of agency in Olivia's reflective accounts of her narratives and the relative impact on her identity transformation. Demonstrating a definite appreciation for deep reflection as a vehicle for yielding up personal meanings and reasoning the status of her selfhood, which Olivia mentions at the end of her first undergraduate year.

Viewing her narrative through the lens of self-regulation theory I consider Olivia to be demonstrating a comprehensive capacity of knowingness (Clarke, 2017) an ability to show self-awareness and self-regulation, and in aspirational capital terms, a form of resilience. Her facility for metacognition appears to have developed significantly, the reason for my earlier interpretation that the nature of her personal transition appears to be founded on 'transitioning by self-knowingness', and I think this is encapsulated perfectly well in Olivia's expression,

> "I mean you reflect on your identity, and you are improving you." [N2]

It is a self-regulating process of knowing yourself and adjusting one's behaviour; accordingly, very much a metacognitive process. Being an agentic person and self-determined to instigate new aspects of her life, is easy to recognise in Oliva. For Van Manen (2016, p.14) 'sense of being' is both a view of who we are and an ongoing self-forming process.

Case 4 - Sarah:

Over time, there has been a higher prevalence of WP schemes to reduce elitism in access to higher education. To gain access to university for her first degree, Sarah took part in two access courses, which demonstrates her high level of agency, a determination to pursue the life she wished to have.

The American transcendentalist author and philosopher Thoreau (1854, p.321) suggested that one should, "go confidently in the direction of your dreams, and endeavour to live the life you've imagined". Whilst Sarah is unlikely to have been aware of this motivational saying, she has had a long-term dream of becoming a doctor, which has certainly been motivational for her, and this has been punctuated throughout her story. Despite this, Sarah did not perceive herself as being the best student nor attending a good school. She stated that the school was set in a deprived city area where academic achievement was not very high.

> "I was a mediocre student … was in the top set for Maths and English [however] the bar wasn't set too high, so it wasn't an achievement to be in the top set there." [N1]

With poor results at the end of the first year in 6th form Sarah had to drop Chemistry and Maths, and was offered to substitute them with Sport, which she refused.

> "I'd rather do something a bit more academic, so asked if I could do A level Law, doing two years in one, along with Biology and Psychology." [N1]

The school did not provide guidance on applying to medical school, but her mother was very supportive with online searching of different schools of medicine and driving her to hospital every day for a two-week shadowing experience of a cardiologist, who was the father of a friend she knew from a weekly dancing class. In addition, she attended a two-week university widening participation scheme, so that she was given a contextualised admissions offer to access a biomedical sciences degree, which was realised.

> "… when I first got there, I thought, oh my goodness, I'm out of my depth because … the people you're living in a flat with … they were lovely people don't get me wrong, but I think because we're all from quite different backgrounds made me think maybe I'm not intelligent enough to be at university…" [N1]

Sarah specifically noticed some socioeconomic differences with her flat mates, which lead to feelings of 'imposter phenomenon'.

> "…. I just started to notice specific things, even silly things like when you first got dropped off, and you had to buy bedding. My Mum had sent me off with something like the cheapest sort of thing and it's still bedding in my eyes – like it's still a duvet, whereas my flat mate was getting really exquisite duck feather pillows and duvet …… Sounds silly but I think that was one of the first things I noticed that really set us apart." [N1]

Whilst there have been some self-doubts about feeling 'out of place' or having low levels of competence, highlighted in her suggestion of experiencing imposter syndrome, her feelings about her accent and not fully belonging, have not impacted on her chosen path. Sarah's strength is demonstrated by a high level of metacognition and considerable ability to reflect on her own ongoing transition seems to have kept her on track. An aspect she did emphasise was the period of social distancing and online learning due to the Covid-19 restrictions.

> "I think it would have really been beneficial to have been in person." [N2]

The extended period of study for Sarah, following her 3-years undergraduate in biomedical sciences and now the additional demands of 30-hour weeks of employment to self-finance her tuition fees indicate her determination despite the total demands on her time.

> "I have quite struggled with the workload, … managing to balance Uni alongside my part-time work. It has actually been quite isolating at times, and I feel as though I've had to practically cut out socialising just so I can keep up … which is a shame." [N3}

It is clear to see that Sarah is demonstrating determination and intrinsic motivation to reach her goal, and it is certainly not an easy path.

Case 5 – Ziya

For Ziya, in the context of early experiences of school and home, and the journey narrated in her ongoing story, the two elements of her identity which seem to be current are her resistance to cultural expectations and a skill to reflect deeply on her transition over time.

Her early experience in school and the restricted interaction with peers and teachers, led to an absence of motivation, engagement, and sense of belonging. The epiphanic moments changing her enjoyment and meanings of learning were sparked by a positive interest afforded by a particular teacher and a support tutor. Not only did this interest and support initiate a junction of cognitive and emotional motivation.

> "…all of a sudden, everything just boomed, my brain boomed." [N1]

There was also support for her to access a private school close to home, mentorship from her teacher and support tutor. The change in culture was two-fold, firstly between that of her primary state school and the private secondary school. Secondly the variation between her ethnic community and family expectations of what a female should do with her life, and what the educational trajectory for medicine might require. Ziya gained cultural capital from the private school, which helped her in the transition to university.

> "I started to realise that a lot of these kids are naturally from very stable backgrounds." "… we start to talk to all these parents … and there is a bigger world out of where I live, which I wasn't initially exposed to, especially because my parents don't speak English," "And then my dad, he doesn't have education at all." [N3]

Ziya is clearly able to navigate herself through this form of cognitive dissonance to justify the path she is creating for herself, to my belief she is progressively curating her own personal transition by reasoning the ongoing experiences and the meanings attached to them. Frequently, she refers to learning more about her religion and realising a discrepancy between religion and the cultural expectations of women, where there is a perceived obligation to marry, have children and be 'settled down' at specific times in life. In this sense, Ziya is resistant to these cultural norms, is very

aspirational and agentic, and clearly reflects on the changes to her identity. Resistant capital was evidenced in her rejection of the non-constructive comments directed at her by relatives or members of the community.

> "…. I can't really get told, oh you're not going to have a life, you're never going to settle down, you're not going to be able to do this or that" [N1]

Ziya is very open minded and open to ongoing life changes and often indicated elements of 'resistant capital' in her outlook and some of the restrictive views within her culture. This is especially the case with her transformation from a shy girl, never speaking at school, in a school where education meant nothing to her, to the undergraduate medical student she now is.

Now Ziya recognises and values the interactional opportunities to learn collaboratively with tutors, peers, and patients in what she refers to as communication boosters. Ziya's representation of lived experience, world view and expectations of her family and immediate community, underpins her reaction to it.

Case 6 – Aura

Aura's family background was set in a working-class community, though she gained a full bursary to attend a private school, and her aspirational family encouraged her to aim for the security of higher education and not follow in the family retail business. Although, the private school did not provide the requisite level of teaching for her predicted A level grades to gain access to a UK medical school, her father was proactive in sourcing European medical schools as a safety net. This exemplifies elements of Yosso's (2005) both 'aspirational' and 'familial' cultures. Eventually, she decided to accept the offer of a Foundation year course in Clinical Sciences, at a university close to home, with access to the course based on widening access criteria, principally the home post code.

Aura considered herself to be an independent learner and tended to compensate for the less than satisfactory teaching.

> "… with my biology teachers being quite muddled up, a lot of A level Biology felt quite self-taught … everything was just so jumbled. It was like things weren't even in the right order, so it was a matter of sitting down at home and organising everything myself." [N1]

Reflecting on her experiences since leaving school, and the impact of the foundation course and her first year in medical school on her identity, she indicates that she was quite shy at school, however,

> "….it was like my confidence just like shot up. It was so different, and I feel like it was so much easier to engage with people …" [N1]

Beyond her identity transformation from being shy and gaining confidence to converse easily with other students, an example of her current confidence in communication, is that Aura focused on her cultural roots and began working with WP learners from similar backgrounds to herself. She was motivated to work for the 'In 2 Med School' organisation (In2MedSchool, 2024) and tutor students, soon becoming a regional head at a local level, and subsequently in her second year of the degree, becoming a director of the organisation at national level.

> "I wanted to move into the tuition thing because I've got friends, obviously where I live … like my post code – it was right at the bottom. There are some schools that don't even do Science A level, like people going to Uni is just not an expected thing…and they'd be like 'Why would I apply?" [N1]

> "I feel like that's sort of part of how I got into Med school [it] is part of my identity." [N2]

Her intrinsic motivation is to support other widening participation students and hone her skills as an independent supportive student, and as she said at various points, to 'give back' or 'pay it forward' to those who are less represented in medical education. The proliferation of ongoing support like this, within the context of WP policy and initiatives will be considered in the discussion, Chapter 8.

Aura's confidence and self-efficacy beliefs seem to have increased progressively over time, and her disposition is the ease by which she can reflect orally on her lived experiences and transition generally; particularly how she has had the opportunity in these interviews to reflect openly and at length about her perceived transition. She has placed considerable value on the opportunity to participate in this research project, which she believes has had clear benefits for her in recounting her transition and making meaning for herself.

Inviting her to reflect on the conversations we have had during the three interviews, Aura said,

> "I have thought about, and we have discussed things that you wouldn't have normally."

> "You know what, I think if it's one to one rather than in a group, I think it's definitely beneficial because it gets you to reflect, but in a positive light". "Feels more like a conversation than a formal reflection, doesn't it?" "…I'm just used to sort of formal reflections, writing things down for assignments, but this is just a conversation." [N3]

My reason for discussing and elaborating on the conversational manner we conducted the interviews, during the final interview, was to explore the relevance of dialogue, with the participants, was to consider their perceived value and utility of verbal reflections for transitional journeys. The underpins the justification for the additional data collection

Case 7 – Loki

Loki's interest in healthcare began early, due to having a nurse in her extended family, her mother diagnosed with a terminal illness and being motivated to learn about genetics during A level biology because of losing two siblings with a genetic condition; and her youngest brother being frequently admitted to the emergency department for swallowing erroneous objects he shouldn't have done. Spurring her on to think seriously about medicine, Loki initiated a placement during her sixth form career in a care home for end-of-life patients. These first-hand experiences created the drive for her to pursue her dream and overcome some of the obstacles in her educational career, which included some mental health issues.

> "[It] …was when you do GCSE and A levels, learning about genetics … was probably the one topic I was always looking forward to, "… "the biggest things that I have learned, especially through work experience is that it isn't just about curing people. It's also about making sure that people are comfortable." "… There was something about helping people and being there for people at their worst moments that both inspired me to go into medicine and also in terms of me coping." [N1]

Loki remarked that although her parents had not experienced much formal education themselves, and were not able to support her directly, they did prioritise education, which gave her some extrinsic motivation to learn. Despite the effort made in her Sixth Form studies, she did not quite gain sufficient grades to enter medicine directly. Subsequently, she accessed a foundation degree in Clinical Sciences. Loki is a self-directed learner, though she admits to having had some dysfunctional revision habits particularly a month or two before exams.

> "I tend to get panicky and then because I've got anxiety as well, so my anxiety gets triggered, and all my revision habits become really unhealthy." [N1]

Her capability to reflect deeply, which is far reaching, demonstrates a strength which has proved to be very effective, not only to recount her story in detail, but also to develop insights into her university transition and mental health state. She firmly believed that talking openly about her mental health is imperative for wellbeing and for her peers too. Indeed, Loki suggests that there ought to be more openness generally in medicine and particularly during the first year through dialogue, to ease students through their early transition.

Her feelings about the impact of Covid-19 in the first year was understandingly mixed, the pressure of working from home [alongside her mother and siblings who were not attending the workplace or school] and not having the social interaction with peers. The relative normality of Year 2 however, made a marked difference to Loki's experience, particularly with the opportunity of placements and

the impact those have made on her confidence, self-efficacy beliefs and consequent changes in her identity which, by her admission, has stemmed from the positive feedback received.

> "I think as we go more to face-to-face teaching, it will be another time to find a sense of belonging. Like I don't think what I've currently found is permanent … because we haven't had any sessions on campus." "Even when it's face-to-face, it's usually in a big lecture group, so I think in that sense it's quite hard to develop relationships with certain tutors, whereas…in terms of personal academic tutors or even like IDEALS [module] tutors, because it's someone you see in a small group setting where you are discussing certain issues which are sensitive anyway." [N2]

In terms of the impact of Covid-19, social connectivity, and relationships, it seems there have been varied outcomes for Loki, reducing opportunities for academic and peer relationships, and increased interactions for family relationships. On several occasions during our conversations, she has commented that on previous situations with students in her earlier foundation course, her cousins and others who wished to apply for medical school, where the relationships have not been reciprocal. These social interactions had made her feel very uneasy.

> "Sometimes I just get the feeling that I just don't really have a proper identity – [it's] like a broken identity, and I think this all relates to how I think people perceive me … I feel this year I've sort of realised people who genuinely care for me and people who will just sort of, I guess use me."

To tease out in more detail what Loki's meaning of a broken identity was, I asked if she meant it is 'in bits' or she was still forming her identity? She replied,

> "I think it would probably be a bit of both, I think there is an aspect of me trying to figure out my identity, but I also think there is an aspect of identity where I have formed it." [N2]

On her first rotational placement with a GP practice, the supervising GP had said,

> "You know you're gonna be a really good doctor, like you're really smart … I don't know how you know this stuff as a second year but believe me, you know a lot more than I did as a second year." "I had a smile on my face for days" "…. And then if imposter syndrome kicks in or I feel overwhelmed with everything, I just think back to what she said." [N3]

In terms of other experiences in clinical settings it seems as though Loki was developing a professional belonging which was gradually transforming her identity and enhancing her transition. Clinical experiences commencing substantially in Year 2, appear to have the capacity to increase self-efficacy beliefs, develop a professional belonging, and transform identity.

Case 8 – Ellie

Ellie was fortunate in attending good schools in her locality, with much encouragement and support from her single-parent mother, so in this sense there was evidence of familial capital (Yosso, 2005) including her mother gaining a healthcare work experience for her in a GP practice. Despite the secondary school being a prestigious one in the area, she did not receive a good level of support in preparing for medical school application. However, Ellie accessed the medical schools of two universities which were delivering 'pre-access programmes' and decided to attend both. Referring to herself as curious seems to be a marker of her eagerness to learn and a level of agency. In terms of her identity and perceiving herself as an independent learner, she believes that by the end of her GCSEs she was more focused and did not expect to be spoon-fed. In the sixth form college she opted for biology, chemistry, and maths, although she did not receive any specific guidance for accessing medical schools.

> "…. But because I am curious, I got onto the medical base of the schools, that I spent the majority of the summer of my 12th year doing." [N1]

Demonstrating elements of an independent learning style, Ellie commented that from the middle to the end of her GCSE's,

> "It kind of became the point of understanding that anything I want to learn, I need to kind of focus. I'm doing that more often, not just expect everything to be fed to me." "Especially during lockdown, you had a new way of working or watching a video that is not really as helpful." "…if people have a question like a problem, they put it online. You get 10-15 people offering their help. I think that kind of help eased any worries." [N1]

This social connectivity was clearly important for Ellie. Particularly during the pandemic and the necessary restrictions. Though she did comment how she had been proactive when coming to university to reduce her fears and create some essence of belonging.

> "I think the main concern before I came was getting into a routine, like the group of friends I have currently, I was actually speaking to them for months before I came to [city]. So, when I came and it was a little unsettling, but it wasn't like having to find new friends and form new bonds, when I have been speaking to these people for quite a long time." [N1]

Getting in touch with future peers prior to starting higher education demonstrates both agentic and proactive behaviours which has the possibility of increasing social belonging and a potential to reduce anxiety on entry. At the end of the first year, she commented on the impact of Covid-19,

> "It's not been a good life in confinement, and trying to separate it, and a kind of stress of it all." …" I want to get that conscious effort to be in the different libraries and being on campus, I've done things through [the university] like reading instead of being in [the university] but not being on the campus." [N2]

These thoughts from Ellie align with socio-geographical theories of 'place' and 'space', indicating the relevance of physical space to feelings, mediated through 'in-person' social interaction. In reflecting on any perceived changes in her identity since the start of the degree, Ellie suggested:

> "I think I have become quite a lot more self-assured, but as we have feedback, and we've been getting feedback and we grow from always needing that constant feedback, has helped me to feel confident in the way I was going. The feedback we receive and the way we respond to it, where and how that can change you and your patterns of thinking." [N2]

The mastering of new knowledge or skills, and the concomitant self-efficacy beliefs impact on identity, who we believe we are at a particular point in time, and the associated emotions, are relevant to how personal transition is perceived.

> "… it always inspires confidence, so it's not just kind of believing you can do it, it's kind of a double-edged sword always, which is quite beneficial for me because that's how we grow. And you don't always accept how much you have changed in a short space of time. But I think I have. I think it's going to help me a lot speaking to different people outside medicine, which I do for quite a lot of the time." [N2]

Ellie indicates a capacity for deep reflection and ability to interrogate her own being, a level of self-perception and self-acceptance. Almost at the end of Year 2, reflecting on the two years, Ellie expresses a particular view on the Covid-19 situation and her distinct feelings of transition between the early period of restrictions and the opening up of the campus, an opportunity for clinical placements. It may be possible to view the starkness of transitional change between the two years, where social expectations are marked by a point in time, before and after a liminal moment between closed and open possibilities for face-to-face interaction.

> "Our weekly sessions were completely online and now we've moved this year to in-person, it's made it more real. So before, I kind of still felt like I was in Sixth Form almost. Now I can think of myself as a medical student and like being on placement in person and speaking to patients." [N3]

This perspective of Ellie perhaps indicates the interface between the social and the personal, with the restricted Year 1 producing a type of 'sixth form identity' and a Year 2 'medical student identity'.

We might consider that identity in one respect is always both social and personal, where the social context provides an opportunity for changes in self-perception and potential identity.

More specifically, Ellie considered that transition is more of a 'shift' in identity than a 'change' in identity, and asking her to elaborate on her thinking, she replied:

> "I think that 'change' kind of implies a big thing, but a shift can be really subtle and have kind of butterfly facts. That's how I'm kind of separating them. A change being kind of a switch …and shift just being more of a gradual kind…without you noticing it happening." [N3]

With further elaboration, she thought that differentiating between the two was linked to the rate of change, the effect of a shift is a slow rate of change, so slow that sometimes it's imperceptible. On asking her to reflect on her transitional journey overall, Ellie focused on her widening participation background and suggested that we live our lives forwards but often view them backwards.

> "I think one thing for me is, obviously one of the pillars of me getting here through widening participation, and that's something that I've used quite a lot to reflect on … we're kind of working with widening participation organisations to kind of spread the message and the voice. And I feel like that's kind of how I reflect through helping others gap to the first stage [from sixth form to medical school]" "Yeah, this intervention that's just finished …two people that I've helped to support have got unconditional offers to medical school, which is great to hear …then one individual has got into veterinary." [N3]

Summary

The ideographic approach to this chapter, as a micro-centric level of analysis, has shown how each of the eight case studies illuminates the unique and transitional experiences of each student, as they narrate their personal lived (and living) experiences. Of particular interest, has been the impact of their medical educational experience, by the end of the second year, particularly on their changing identities and transitional journey. In the following chapter, these narratives are re-analysed to explore the possibility of similarities or patterns across the eight case studies in the form of themes.

7. FINDINGS PART 2 – THEMES

Introduction

Having considered the eight individual cases ideographically, the features within them, and in trying to be true to the individuals and reflecting on their narratives as they were told to me, there are some commonalities or patterns which stood out for me. This does not mean that reframing the data implies that there is a discovery of some form of a global truth (Grant and Grant, 2022). We must consider that knowledge provided in these findings, and this qualitative study is related to its context of origin and the interpretation by the researcher (Grant and Grant, 2022, p.23).

The type of analysis, underpinning the approach adopted in this chapter is a paradigmatic analysis outlined by Polkinghorne (1995), which sensitises the researcher to appreciating conceptual or theoretical knowledge in the form of themes. This appreciation is not to deductively use existing theoretical categories as a vehicle to fit the data into, but to support or extend concepts in the investigation of the participants' experiences and meanings they attach to them. This discussion of the evolution of themes is a further distillation of the data, based on Polkinghorne's (1995) second type of analysis, 'deductive paradigmatic analysis', outlined in Chapters 5 and 6. Methodologically, I needed to recognise how themes evolved, and implications for understanding the transitions of FiF medical students. Using Polkinghorne's framework, a theme was triggered for me in the three possible ways, indicated in Table 17 below.

Forms of narrative links in the data	Examples of potential forms of alignment
Narrative strikes a chord with existing theory or concepts	Self-efficacy beliefs or transformations in identity
Specific narratives of lived experience which links two or more participants	Alternative assets demonstrated by two students e.g. navigational or resistance capital, Yosso (2005)
Narrative links to previous studies in the field (referenced in the literature review)	Independent learner identity indicated, e.g. Macfarlane

Table 17. Inductive evolution of themes using Polkinghorne's framework

However, I must emphasise that although the previous reference to 'deductive' being associated with Polkinghorne's (1995) second part of data analysis, my intention was to pursue all narrative data inductively as much as possible, thereby valuing the student voice and perceived truth. Experiential learning and increments of medical knowledge in the field of the undergraduate programme, as well as students developing self-directed learning skills, are central to a successful transition. However, we might question what constitutes a 'successful transition'. It may mean that an individual feels in

control, and therefore has a sense of agency, or indeed a student metacognitively having a sense of agency. It could mean gaining successful grades and accessing medical school or receiving positive feedback on a clinical placement. Successful transitions might be different and personal for each, and every medical student, but the process of transitioning could be common to all. This is a possibility I wish to pursue in relation to Research Question 2: To what extent does the study contribute to the theorisation of transition? There were multiple ways in which themes evolved from across the eight individual case studies.

The order in which I present the themes is to indicate my perceived conceptual linkages through the routes of knowing and understanding, the socio-cognitive process of identity, and finally personal understandings of self-transitions. However, I wish to emphasise the interrelatedness of all the themes within my all-encompassing perception of personal transitions. These are represented in the schematic figure 3 below. Conceptually, I perceive the six themes, having evolved from the narrative data, to be integrally linked both horizontally and vertically within the holistic formation of the participants' personal transitions.

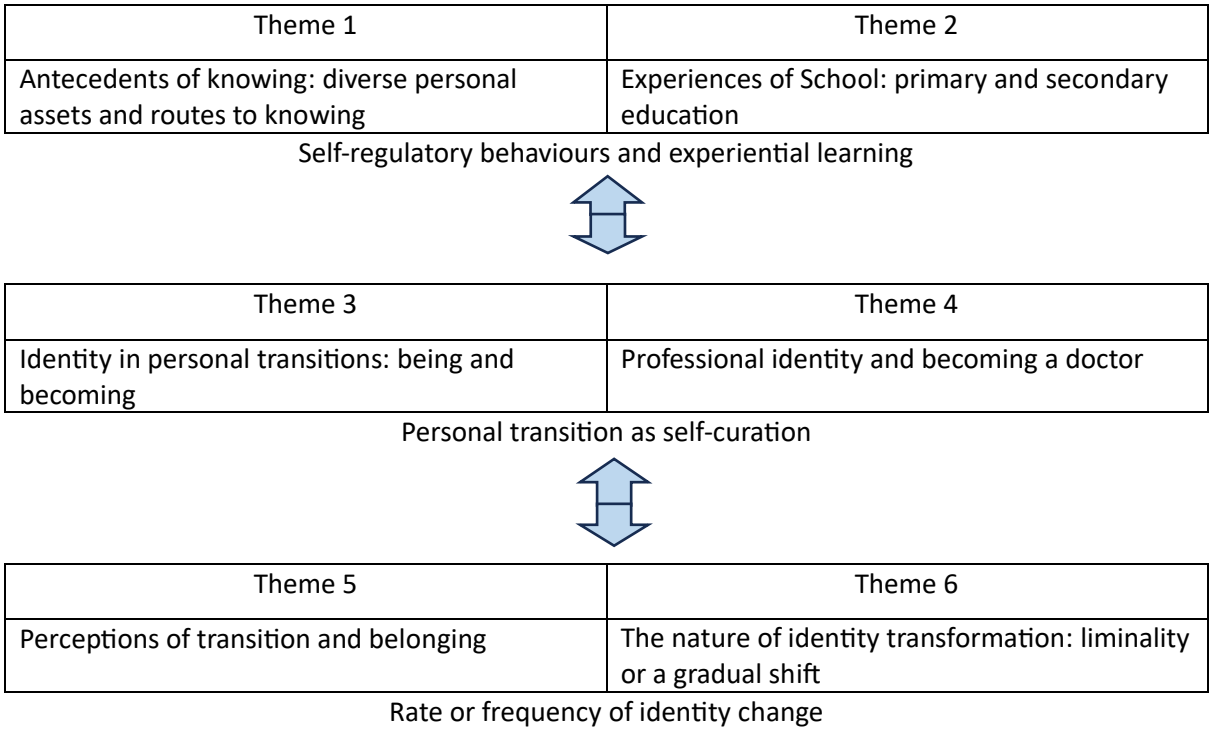

Figure 3. The interrelational links across the themes

Theme 1. Antecedents of knowing: diverse capitals as personal assets

Knowing or having access to medical or healthcare professionals can provide social capital in Bourdieusian terms, through significant others, in the form of networking or gatekeeping to access

relevant work experience. Subsequent experiences in healthcare settings create knowledge through 'cultural capital' and an advantage of experiential learning in the field of medicine and medical education. However, other forms of capital, indicated by Yosso (2005) and O'Shea (2016) suggest alternative, but equally advantageous assets held by some students to explain how they transition effectively through education. It is worth noting that some of these assets, suggested by Yosso, might be individualistic and not necessarily transferred socially.

This theme helps us to explore three questions:

- What are the routes of our knowledge?
- How and through whom (or what) do we come to know?
- What opportunities are there for us to know, and are they the same for everyone?

Although opportunities to access knowledge may not be equal for everyone, we might look beyond the formal curriculum and consider the hidden curriculum (Giroux and Penna, 1979) and its potential impact for 'knowing' during transitional journeys. In broad terms, the hidden curriculum is learning, which is not openly intended, is possibly unwritten or unofficial, including values and perspectives. Values and perspectives which might be transmitted, for example, through informal or chance meetings with members of the medical profession, possibly through meeting a medical student during a WP initiative event, or a regular appointment with a GP or other healthcare worker.

Essentially, we might consider gains in knowing from situations both inside and outside formal educational settings, some of which might be facilitated by participants' personal assets and capability to gain understandings of the world of medicine and healthcare. Indeed, a potential medical student, prior to accessing medical school, during a previous visit to a GP Practice and consultation with a doctor may have noticed protocols and specific behaviours of the healthcare staff, which impact on learning. Such learnings do not constitute part of the formal curriculum once the student is embedded in the undergraduate programme, but nonetheless, form part of the overall understanding of the profession and expectations of practice. Some possible elements of hidden curriculum are indicated in the examples from the data:

Sarah managed to shadow a cardiologist, the father of a friend she had made during dancing classes, indicating how informal networking can be beneficial. This was prior to Sarah applying for medicine and not part of the undergraduate medical programme.

"And I was very grateful that he gave me the opportunity to actually shadow him." [N1]

Ziya benefited in her Sixth Form, from some of her peers having parents who were members of the medical profession. The students initiated a scheme whereby this group of parents were offered to attend the school and support students who wished to learn more about the profession and apply to medical school. This was not part of the formal curriculum in the school, the parents voluntarily opted to attend the school to help students, outside the normal timetabled classes.

Ziya mentioned that:

> "… parents were consultants, they were doctors, they were nurses, they were in the medical profession … all these doctors came in to tell us about the way they work and the hours they work." [N1]

Theo was taught by a science teacher in secondary school who, in an earlier career, had been a pathologist and was able to impart some understanding of medicine and assist in applying to medical school. Outside his formal science teaching sessions, he imparted some understanding of medicine.

> "… he had come from a working-class background and was very keen on getting students from not middle-class background into medicine, so he worked very closely with quite a few of us." [N1]

Although these examples are focused on pre access to medical school, they do touch on individuals' acquisition of knowing about the medical profession through more indirect, and sometimes, more informal means.

Theme 2. Experiences of School

a) Private schools

Three of the eight participants in the study attended private secondary schools, having gained full bursaries by sitting an entrance examination near the end of their primary school education. We might assume that this would give them an advantage compared to other students entering higher education, perhaps because of private school education seemingly preparing learners for university, and the potential correspondence between the two fields (secondary education and HE). However, we cannot assume that this is always the case, nor can we assume that parents were always

responsible for guiding their children towards a private education. In all these cases, the parents did not have the wealth to send their children to a private school.

For Ziya, who did not speak much in primary school and whose parents did not speak English, but the stimulating experience in primary education, created by a particular teacher and classroom assistant, opened up her mind and opportunities through a transition which was marked in secondary school by her demonstration of 'aspirational', 'resistance', and 'linguistic' capitals (Yosso, 2005). Aspirational, considering understandings of medical profession imparted by parents of school friends, resistant, by rejecting the cultural views imposed by family and community, intended to restrain her views, and linguistic, with a later realisation that being fluent in four languages was a considerable asset in future healthcare settings.

Theo's parents, being from a working-class background, exhibited a form of Yosso's (2005) familial culture with encouragement for reading and self-regulated learning, and suggestion that she could apply for a scholarship, as she had been performing well at her primary school.

> "So, I sat the exam, managed to get a scholarship into a private school so when I was 11, I went to private school for my secondary school education. And I think that, coupled with my sort of my parents raising me in this culture of learning, is very, very important thing. That was what set me on a trajectory towards medicine, I suppose." [N1}

Subsequently, she gained some cultural capital around an understanding of medicine from her school friends' parents:

> "… I had a couple of friends [whose] parents are doctors … I think sort of getting a chance to speak to them …so I think from them I got more because … if you've not had much experience in medicine, it's really easy to romanticise it." [N1]

Additionally, for Theo, the teacher who had been a pathologist, mentioned in Theme 1 above, also augmented her understanding of a career in medicine.

However, the experience of private education for Aura was distinctly different, with the quality of teaching and support for entering medical school being impoverished. This arose from a situation when an advisor who supported those students who wished to apply for medicine, dentistry or pharmacy retired from the school due to illness and was not replaced.

> "… when we were in Year 12 in the first term she got diagnosed with cancer. So that meant her role couldn't continue and they said that they were not allowed to fill that gap." [N1]

Following a succession of different Biology teachers for A level, Aura said:

> "… with my biology teachers being quite muddled up, a lot of my A level Biology felt quite self-taught… because everything was so jumbled. It was sort of like things weren't in the right order, so it was like a matter of like sitting down at home and organising everything myself." [N1]

Therefore, a collaborative group of like-minded peers, worked out the requirements for entering medicine, it was perhaps an example of collective agency underpinned by a combination of aspirational and navigational capital (Yosso, 2005). She and her peers organised extra-curricular events to host a few parents who were members of the medical profession, to share knowledge of pursuing medicine and to provide guidance in applying for medical school entry. One might assume that the school staff might have initiated such events, but in Aura's case it was the students who were entrepreneurial in organising supporting events.

Attending a private school can be a source of confidence building and stimulation, with students generally leaving with better qualifications and progressing to university (Henderson et al., 2020). However, the authors suggest that the progression of privately educated students to elite universities is based on them choosing what they referred to as 'facilitating' A level subjects, preferred by elite universities. They classify these preferred subjects as Modern Foreign Languages, Biology, Chemistry, Mathematics, Further mathematics, Geography, History and Physics, amongst others (Henderson et al., 2020, p.308). It could be argued that students will be applying to study medicine with a potential subject profile of Biology, Chemistry, Mathematics and possibly additional subjects such as Psychology, Physics or English Literature, therefore at one level, a private or state school education is irrelevant. However, there are other factors which will impact on worthy applications to medical schools e.g. relevant work experience and interpersonal skills which may be explored and exposed at an interview stage.

Private schools may also have staff who are connected to friends and relatives in the medical profession which can open up relevant work placement opportunities. The small teacher/pupil class ratio potentially allows teachers to spend more time with each pupil supporting the University applications process.

b) State Schools

With all the first interviews, I invited the participants to consider their 'back story' about family, friends or school, to contextualise the overall story as a FiF student coming to university. Liz outlined her early years in school,

> "…I was determined I was going to be a music teacher or work in opera… I used to be a private tutor of music; I dedicated my life to it utterly." [N1]

> "… I realised halfway through the year I wanted to do the Sciences." "My father and my dad's side of the family was really disapproving of me – wanting to do the Sciences …" [N1]

Despite comments by members of her family, Liz was determined to pursue a science route in her education and demonstrated aspects of resistance capital Yosso (2005), not only resisting the reluctance of her school to allow her to change from music to science, but also the pressure from her family for her not to pursue science. Essentially, she was a self-determined, independent learner,

> "… I didn't have somebody to guide me because no one in my family have done anything educational, it's literally working-class jobs and manual jobs really" [N1].

Her continuing intrinsic motivation to study and a capability in science facilitated satisfactory progress, though Liz's access to HE was problematic. Taking extra time to complete A levels required for entry may act as a barrier to medical admissions. Possibly, had Liz been educated in a private school, she may have been advised that extending her time on the A level programme could impact on her HE entry requirement. However, taking an access route with her A level qualifications brought her eventually to successfully accessing medical education.

Similarly with Olivia, the early part of her secondary education was more on an Arts pathway than science, and successful G.C.S.E. examination results proved to be a significant motivator in changing direction.

> "I wanted to be an architect or fashion designer, or something artie, I was a really creative person. I only really changed right at the end of GCSE's so only two years, or a year, before the application process started." "…my GCSE grades proved that I had the capabilities of doing more than I thought." [N1]

Beyond volunteering in community care homes, Olivia commented that,

> "… the way I learn, and revise best is by teaching other people" … "...I had a job as a tutor throughout A Levels … all three Sciences and maths, only at GCSE level but I still loved it." [N1]

Whilst these experiences for Olivia could have been the same had she been educated in a private school; I have included the example to indicate the seemingly intrinsic motivation and self-regulatory behaviour of some learners despite the context of the education system.

Olivia was so enthused by learning, that before and during the Covid-19 lockdown period, she completed 30 of the MOOCS.

Ellie considered herself very lucky because of her good primary and secondary state schools in her locality, and following good grades transferred to a 6th form to study Biology, Chemistry and Maths, specifically chosen,

> "… based on the idea that I'm going to do medicine..." [N1]

During this time, she was proactive in contacting two universities and attending the Access Schemes of both and particularly benefited from the mentoring received for writing application statements.

> "The most help I had was from a 3rd year medical student who kindly read it for me and pointed out some areas I could have improved. They were the kind of key figure in helping me apply." [N1]

It is possible that more positive help and mentoring to complete and submit University entry documentation might have been provided in private education, with a higher proportion of the annual cohort progressing to HE.

In comparing all the narratives across student experiences within the state and private school sectors, there is not a clear differentiation between the two systems in terms of quality of provision or personal learning experiences. What comes to the fore is essentially the intrinsic motivation and self-directed learning skills of all nine participants to be future focused and 'navigate' their own personal transitional route, along with some examples of Yosso's 'resistance' and 'aspirational' assets, or capitals. These are some of personal skills which align with the centrality of identity in the framework of personal transitions, which will be considered further in the Discussion, Chapter 8.

Theme 3. Aspects of identity in personal transitions: being and becoming

Elements of identity and the nature of changing identity appear to be central to transition and the two may be seen as inextricably linked. Transitional change from one state to another during an episode in time or a specific experience, may impact on the personal awareness of the transitional process and perception of identity. Conversely, a particular nuance of our identity during an episode of reflection may result in a reformed view of the transitional journey, a process which contemporaneously encapsulates both identity transformation and feelings of transition.

Liz believes,

> " … identity seems massively changeable throughout medical school"

Starting medical school, she said:

> "You create a new little aspect of yourself … a situation where you merge your identity with the new identity you have formed." "…[I] merge myself with what I want my future self to be." [N1]

Implicitly, Liz seems to be actively considering her being and becoming by creating what she wants her future self to be, using reflection and self-perception. Similarly, Theo too, often indicates her capacity for deep reflection, particularly around her clinical exposure and its impact on her transition.

> "I think it's sort of something you kind of have to do [reflect], because you are very much aware that this is a big step, and you are definitely changing as you go along, and it is something you need to do in the medical field because you need to keep track on how you are improving …" [N3]

Ziya says,

> "It's been great looking back and reflecting on how far or how much I've done, … and interacting with peers, … without realising, there has been a reflection [that] there's definitely been a change … when it comes to transitional change". [N3]

Ziya also mentions 'interacting with others' which indicates that identity is not being formed in a vacuum, she suggests it is a social process. She is very open minded and open to ongoing changes and indicated elements of a 'resistance capital' (Yosso, 2005) in her outlook and the restrictive views held in her culture. Resistance capital is where an individual is more likely to be self-determined and does not easily succumb to pressure from others, particularly if the individual perceives some level of internal conflict with familial or community culture.

Being and becoming is made possible by the decisions one makes to be a particular person or deciding to go against one's family.

In terms of being and wanting to become something else, Sarah considers,

> "I'd like to become a better person and evolve as time goes on. I feel as though I've got a lot more to lose now if anything was to go wrong, or if anything was to be interpreted in a different way to what I had intended …" [N3]

Later she continues:

> "I definitely feel as though my professional identity has changed. It feels more real now, as though we are actually going to be doctors in a few years, as opposed to just being students for the rest of our lives." [N3]

Similarly to Ziya, Sarah refers to the social element of transforming identities in her use of "we" and "our" in the 'becoming doctors' process, a group of peers' transforming professionalism.

Aura talked freely with others about how she perceives her transition and shifts in identity.

> "If you'd had met me through secondary school, or in sixth form, you would probably think I was the shyest person ever, and I don't know what happened." [N2]

In summary, we might recognise that students may experience 'becoming' as an interactive process with others, peers, family, teachers, or further along with patients, as clinical placements become more common. Reflection is always part of this process, which will be considered in the Discussion, Chapter 8.

Theme 4. Professional identity and becoming a doctor

The curricular transition from Year 1 to Year 2 for all medical students is specifically a marked one, where exposure to direct patient engagement is usually distinct across the two years. With this specific cohort of students, it was a starker experience than usual, because of the severe Covid-19 restrictions in their first year. Theo emphasised the impact on her personal transition and identity in Year 2, as a

> "a shift in belonging to the university and going on placement and getting to do things a doctor would do". [N3]

Olivia, on a placement in primary care, received feedback on her excellent communication with patients, greatly increasing her confidence and affecting her identity. She remarked that she was,

> "… self-curating an idea of professionalism". [N3]

Indeed, the possibility of self-curating professionalism might equally apply to the possibility of transition, being one of 'self-curation', within the context of ever-changing social contexts and the interactions between the individual and their environment.

My belief is that this identity work, which students will be continuously experiencing, could be motivated internally or externally, or by a combination of the two. If we consider external motivation, then the institution has a major role in supporting these transitions. Hattie and Timperley's (2007) contribution to the field of constructive feedback is a model for educational practice and propounds that providing and receiving feedback requires skill by both tutors and students. For students, receiving and working with feedback on their professional development can expand the meanings they attach to ongoing progress and self-efficacy beliefs.

Sarah's account of taking blood successfully on three consecutive occasions positively transformed her professional identity, and self-efficacy belief, from the feedback on her competence level. Aura outlined the impact of her placement in respect of her transitional journey, within secondary care. She described developing an understanding of advancing technology of tumour ablation in cancer treatments. This experience, and increased understanding, made her feel more like she was becoming a doctor, this essentially is an example of internal or intrinsic motivation for identity transformation.

Similarly, Loki received very positive feedback from a supervising GP on placement, which not only impacted on her identity at the time, but also in subsequent weeks when she commented that whenever imposter syndrome arose for her, she would think back to what the doctor had said. This was particularly important for her, with regards to self-regulation of emotions. Likewise, Ellie outlined how she applied her skills of free association thinking, examining thoughts and words coming to her mind, seemingly demonstrating a capacity for reflection and metacognition. A prominent feature of these comparative findings, across all participants, seems to be the illumination of some level of 'self-curation of identity', which requires the skills of deep reflection, agency, and reflexivity on the part of the students.

Theme 5. Perceptions of transition and belonging

There may be several reasons why students feel a sense of belonging, or not, in the field of higher education, both of which could possibly impact their emotions and identity. A case in point within this study, was the period of restrictions following the outbreak of the Covid-19 pandemic. The impact of online delivery and absence of in-person social connectivity on campus were considerable, though the perceived impact was variable across the participants, as outlined in their personal reflections.

While Ziya was considering her overall journey during Year 1 she remarked,

> "I don't think it was the bumpiest journey [but] there are certain things that if they hadn't been there, for example, if this whole Covid-19 situation wasn't around, it caused a more difficult journey." [N2]

Similarly for Aura, her view of Year 1 was,

> "…you don't get like a secure sense of belonging until you've been somewhere in person, like physically there…not built any rapport with lecturers, …not with your fellow students or anything like that. Feeling a sense of belonging isn't as strong." [N2]

Conversely, Aura perceived some advantages of experiencing delivery of online learning, as it removed the need to commute from home to the university:

> "…that would be like an hour in the morning, an hour at the end of the day, that's like 2 hours of your day eaten up." [N1]

Theo referring to the end of Year 1, transferring into Year 2 when the university Campus opened following the lock-down period, indicated,

> "I definitely do have a sense of belonging now. It wasn't so much …I didn't really have that sense at the beginning [during Covid-19 restrictions] but as I've sort of gotten to know my peers and the school itself, I do definitely have that feeling." [N3]

These kinds of thoughts align with socio-geographical theories of people and place, where familiarity with specific places, and people who occupy those spaces, impact on sense of belonging and potentially feelings of wellbeing. Ahn and Davis (2020) suggest four domains of students' sense of belonging to university, 'academic', 'social engagement', 'surroundings' and 'personal space', some of which were impacted during the pandemic restrictions.

In terms of 'othering' or otherising another person or group, as being intrinsically different to oneself, might come into play for any student starting university, and impact on sense of belonging. Points of perceived difference may be based on class, accent, ethnicity, or possibly multiple aspects of intersubjectivity. The following thoughts in the narratives indicate some examples of this phenomenon, which might impact on perceptions of self and others in relation to self. Sarah indicated that at secondary school she was only:

> "a mediocre student" [N1]

but demonstrating a level of navigational capital (Yosso, 2005) she opted to enter a widening participation scheme, which permitted a reduced offer to access an undergraduate course. Recognising that her peers were all from different (advantaged) backgrounds, made her think:

> "… maybe I'm not intelligent enough to be at University". [N1]

Implicitly she was indicating feelings of imposter syndrome (The British Medical Association, 2024) as did many of the other participants during the early stages of starting the programme. These feelings and perceptions of difference might materialise in several different ways.

Liz said that many people she spoke to,

> "… come across as middle-class." [N1]

She always felt more comfortable interacting with the few who were working-class like her. Towards the end of Year 2, Liz envisioned a disjuncture between her family's values and her own current ones. Indeed, it seemed that concurrently with her transitional development and perceptions of 'becoming middle-class', there was an element of otherising in respect of how she viewed her family. Her parents continued to give her emotional support, but she perceived they, and she, were living between two cultures, which appeared to be their lack of understanding of her academic life and interests, and her perceiving a more middle-class identity, making communication progressively more difficult. Liz indicated that at times she changed her accent and mode of language in the home environment, indicating a form of reverse code- switching. Code-switching is the way a member of an underrepresented group (either unconsciously or consciously) adjusts their language, syntax, or grammatical structure to fit into the dominant culture (Auer, 2013). In this example Liz was switching to align with her parents in the home situation. Theo seemed to possess aspects of cognitive dissonance (Festinger, 1985), when she recounted her story of being from a working-class family, having had the opportunity to attend a private school, yet having one parent receiving social benefit payments and feeling embarrassed. This seemed to be a particular element of her being.

Sarah describes her impressions when first arriving at university halls of residence, …

> "… lovely people but we're all from different backgrounds" [N1]

… and her mother sent her off with the cheapest type of bedding. Faced with this experience in comparison to other students bringing expensive bedding as they arrived at the accommodation, can trigger one's sense of being 'as a dynamic human life phenomenon' (Van Manen, 2016), which begins to tell us who we are. This 'otherising' process formed by us of 'who we believe we are', and also 'who we perceive others to be (Van Manen, 2016, pp.62-63). Sarah's perceptions were social class based, as were her thoughts about her accent. Her negative thoughts about her own accent were based on assumptions that others would perceive her to be,

> "… less academically and medically competent" [N2]

Even at the end of her second year, Sarah commented on her struggle with impostor syndrome and feeling unworthy of her place at medical school.

In addition to 'othering' stemming from class-based roots, the same phenomenon may arise from a gender, ethnicity, or language basis. Ziya outlined what she believed were cultural problems in perceptions of Muslim women within the Muslim world,

> "There is less expected in my family from a woman". [N2]

Similarly, in primary school, with English not being her first language, she believed herself to be an 'other', and felt ashamed. However, if we consider 'linguistic capital' in Yosso's (2005) model, we can appreciate a considerable advantage of being multilingual, a position that Ziya fully appreciated as she became older, having experienced the world of healthcare, and a potential need to communicate with patients in languages other than English. Ziya was fluent in three languages in total, and in the context of Yosso's model of cultural capitals which some individuals can offer to certain social settings, we can appreciate the advantage of possessing languages other than English in healthcare settings, another resource which would make you useful. I believe it is useful to consider that something which makes someone an 'other', might also be a resource. Over the course of the three interviews, Ziya began thinking that her non-English languages were somehow not relevant beyond the confines of her home, but later fully realised their potential use in healthcare settings.

Theme 6. The nature of identity transformations: Liminality or a gradual shift?

On occasions the participants would reveal their thinking and sense-making about transitions and transformations in identity. I consider that 'successful' transition may mean different things to people, but there could be a common theoretical perspective that transition is implicitly not fixed but change. Understandings of identity and identity change are important, not only academically, but also from the context of how individual students make sense of their continual and multi-factorial changes, understanding their personal evolutionary transition, which is the central purpose of this study.

Through her deep reflections and wide-ranging lived experiences, both in academic and care-giving situations,

Olivia was considerably aware of how she had changed,

> "… in a good way".

In her later story lines, she would always refer to reflection.

Sarah too, demonstrated the ability to reflect on her ongoing transition to keep herself

> "On track."

A distinctive view on identity was that of Loki, by her feeling,

> "…I just don't really have a proper identity – it's like a broken identity."

When gently teasing out her meaning of 'broken identity', possibly as, 'It is in bits' or was she 'still forming her identity', she said,

"It was a bit of both."

Perhaps she was trying to figure out her identity and aspects where she had formed it. It seemed like a case of 'identity work in progress' and a central part of her transition.

It would be useful, in supporting medical students' understanding of their developing identities, to consider personal aspects of how we perceive ourselves, our being, but also how our beings might change over time. How we are now, but also how we might become, and the potential processes of becoming. Ellie, in respect of identity change, voluntarily differentiated between 'shift' and 'change', as two types of transformation. 'Change' she perceived as a bigger thing, and 'shift' as something more gradual. Through our continuing dialogue, she agreed that both were related to the rate of change, shift being something slower and more imperceptible.

To follow this through, we might consider change in respect of liminality, or liminal experiences like a change in role, for example having become a medical student on clinical placement, or a graduate beginning a Foundation Year 1 post.

Supplementary study findings: Student reflections on the personal value of the interview process.

Code	Descriptor
1.	Appreciating deep reflection and efficacy of dialogic approach in interviews.
2.	Recognising value-added for progression of FiF students.
3.	Recognising the impact of dissonance and disjuncture in transition and relevance of the process being therapeutic to address imposter syndrome.
4.	Appreciating the process as non-judgmental and free from academic assessment constraints.
5.	Dialogic reflections might occur during interactions with others (e.g. peers, friends, or partners).

Table 18. Thematic codes evolved from narrative reflections.

The narrative reflections from which the codes emerged were:

Code 1.

"Reflecting allows you to step back … and take in the bigger picture". [Theo]

"I think deep reflection allows you to have a reality check. It allows you to slow down for even an hour and look back at everything that you have done to get here" [Ziya]

"…verbal deep reflection is extremely beneficial to someone like me, all students should be given the opportunity to choose what works best for them in order to reflect." [Ziya]

"I think this would be an incredible resource for students in the future and especially onto a course like medicine." [Loki]

"Another value [of the dialogic approach] is the boost in confidence" [Theo]

Code 2.

"Reflecting on changes you've made between years on the course … or even before you start the course, allow you to realise just how far you've come in such a short space of time…" "…this is particularly useful to those who are first in their families…" [Theo]

"I felt that the reflective process involved in the qualitative transition study provided me with a valuable opportunity to assess how my past / current challenges are supporting my current and future progress." [Liz]

"Reflecting allows you to take a step back … and take in the bigger picture. While you can do this yourself, a benefit of having somebody else asking you reflective questions … it forces you to consider perspectives about your work and university life you may not have thought about previously…" [Theo]

Code 3.

"… deep reflection is almost a way of healing the broken self-confidence." [Ziya]

"There are often many struggles which go untalked about, the idea of not being adequate, having got in [to university] by mistake, imposter syndrome." [Loki]

Code 4.

"I find that this process was free of judgement, specifically mark schemes, engagement points and time restraint, unlike the rushed meetings with tutors and personal academic tutor, it allowed me to focus just on myself, my progress, my mindset, and my goals – an incredibly valuable experience." [Liz]

> "… as an individual I was able to walk away having worked through a range of feelings and experiences which otherwise I may have avoided or just not realised they needed to be thought about." [Loki]

> "One of the best things about the session [interview] however was that it wasn't formal … no pressure to analyse what went wrong or right and what changes to make." [Loki]

Code 5.

> "Another value is the boost in confidence … reflecting on changes you've made between the years on the course … or even before you start the course allow you to realise just how far you've come in such a short space of time" … "this is particularly useful to those who are first in their families … as I feel like imposter syndrome is quite a common occurrence amongst us as a demographic." "… how far you've come shows that you do deserve to be here." [Liz]

> "I do feel that these reflections can be easier to understand when spoken out-loud with another individual, and so I have had regular conversations with my partner about how I feel I am progressing …" [Liz]

Conclusion

Independently, and collectively, there appears to be several narrative features in the data, emerging from the participants' stories of their lived experiences and contemporaneous reflective thinking revealed across the three interviews, which illuminate elements of personal transitions and identity transformations as students progress through their early years of the undergraduate programme.

The themes which interrogate the bases of **how** students come to know, the routes to knowledge, or specifically through **whom** or **what** they come to learn knowledge of themselves and of medicine. We [participants and researcher] considered the possible impact and variety of primary and secondary education experiences, including the opportunities pursued and personal pathways chosen towards accessing medical education. Personal transformations of identity both academic and professional were explored in their journeys toward becoming a doctor, and subjective feelings of belonging to the field of higher education.

Focusing specifically on individual thinking about 'transition' in conjunction with 'identity transformations', is the direction toward an understanding of the transitional process in processual terms. The final section of this chapter, 'student reflections on the perceived value of the style of the interview process', took up the mantle of how deep reflection might be facilitated in conversations to afford a personal understanding of transition, the overt recognition of self-transformations.

8. DISCUSSION

Introduction

What I set out to accomplish with this study was to explore and gain an understanding of how students from FiF backgrounds individually experience their own personal transition to medical school and the early years of their undergraduate programme. The gaps in the literature, in Chapter 3, highlighted underrepresented groups gaining access to HE, though with limited alternatives to the deficit perspectives in the research field, and the limited alternative conceptions of transition to previous standpoints.

Addressing the Gaps in the Literature

There had been limited research of first-generation students undertaken in the context of undergraduate medicine, despite seeing a relative increase of FiF student numbers within continuing annual medical school student intakes. Wright et al.'s (2023) research has been one of the few studies which have focused on FiF students, indicating a limited exploration of students who enter HE through a WP contextualised approach outlined by Boliver et al. (2019). Additionally, there has been a gap in understanding of the unique personal journeys of students through the early stage of their medical education. This study and the subsequent findings have illuminated many strengths of FiF students coming to medical education and successfully navigating the programme through their unique and personalised transitions. Four principal elements of the findings are:

- Students, demonstrating alternative assets on accessing HE.
- Demonstration of navigating own transition through agency and unique competencies.
- Demonstration of levels of self-direction and reflections of identity changes, which impacts on the subjective transition.
- Methodologically, adopting a longitudinal approach was not only appropriate for illuminating personal changes in identity and transition but was rarely used previously in UK and international studies.

In a landscape of social history, I had situated my study within a wider social justice context. Both the The Sutton Trust and Social Mobility Commission (2019) and Laurison and Friedman (2019) indicate where the relative distribution of power and opportunities for social mobility have tended to be skewed. Social change in democratic societies has often been facilitated by a political focus on social justice and increases in social mobility, movements to increase opportunities for those who are the underrepresented groups in elite levels of society (Milburn, 2012; Medical Schools Council, 2016).

Upward social mobility, defined as individuals who succeed in life despite their family background, led me to focus on FiF students to access higher education and specifically medical education, as a high-status career (The British Medical Association, 2009). My view is that there is a moral imperative to widen participation of underrepresented groups in elite professions in UK society, particularly medicine, and challenge discourses of inferiority within such groups.

Considerations of social mobility at a macro level, have been indicated by policy directives and access initiatives which have had some impact nationally and particularly at the medical school at which fieldwork for this research was conducted. Except for the impact of Covid-19, the statistics indicate a progressive increase in the WP student representation, within the annual cohorts over 14 years, which was outlined in Chapter 2.

Whilst statistics indicate a relative increase in the proportion of widening access to the medical school forming the location for this research, there was no understanding of how these medical students experience transition into and through the early part of their undergraduate programme. This study represents a sample of FiF students, who are part of the previously mentioned underrepresented groups in medical education, and their experience of transition to HE and through the initial two years of the undergraduate programme. I emphasise that being an FiF student is but one category of students within the contextualised approach to widening access (Boliver et al., 2019), also referred to in Chapter 2. I had used this category for recruiting participants as possibly the least intrusive of the six possible categories, though aspects of the other contextualised categories were voluntarily disclosed during the interviews, which is reflects aspects of intersectionality.

The assumption is that FiF students are accessing this stage of education at a disadvantage by virtue of not having anyone in their family to provide them with knowledge of HE, which is an inequity. They are comparatively disadvantaged in that they do not have all the advantages, those privileges that other students may have, coming to a system which is set up for students that do have those privileges, with those families who are able to provide the knowledge and connections to forge success. However, I propose that we avoid conflating disadvantage with deficit, as although it might be recognised that FiF students might be less advantaged than others who come to medical education, in respect of traditional expectations of the medical school, that does not preclude other assets, or advantages, they may bring with them. Those disadvantages should not be perceived as a problem, because a more inclusive education can be provided. Equity, diversity and inclusion can become a tenet of good education in the context of widening participation and widening access.

I believe that an issue with the earlier studies using Bourdieu's theoretical model was the inability to consider routes of learning other than the family, the form of transgenerational privilege.

The implications from the findings are outlined in this chapter, following the summaries from the previous Findings Chapters, 6 and 7, which emphasised the micro-centric analysis of the eight individual case studies, which illuminated the unique and subjective transitional experiences and personal transformations of student identities. What did the findings tell me?

This chapter is structured in three parts, with each part principally linked to addressing each of the three initial research questions:

RQ1. How do students from first-in-family backgrounds experience transitions through medical education in the early years?

RQ 2. To what extent does the study contribute to the theorisation of transition?

RQ 3. Are there any implications for how medical schools might support these transitions?

I acknowledge the interconnection between the parts and how they come together in exploring the implications of the study.

Part 1.

Addressing research question 1: How do students from first-in-family backgrounds experience transitions through medical education in the early years?

From what I have heard and read from these students' narratives, this question is partially answered by the detail in their personal stories, with the top three things that participants showed me, as a characteristic of their transition, and in some cases identity transformations being:

- Agency and intrinsic motivation
- Self-regulated learning
- Reflexivity and a level of self-authorship

Whilst these capacities were common to all participants, there were many other idiographic skills, competencies, and awareness of identity transformations, within the sample of FiF participants, that gave novel insight into,

- What does agency and intrinsic motivation look like?
- How is self-regulated learning made relevant to feelings of internal control over learning?
- How does reflexivity and self-authorship constitute change driving further change?

Agency and intrinsic motivation

How do agency and agentic behaviours manifest themselves? As a reminder of my comments about agency in Chapter 4, individuals who feel they have agency (an internal locus of control) are more capable of resisting social pressure, and feel responsible for their actions (Rotter, 2017). As a social agent, we might be regarded as "active meaning-makers in our own lives rather than … passive recipients" (Allen, 2008, p.565).

Some examples of agency and active meaning-making in the findings are:

> **Liz:** "I was quite defiant … But I don't regret it …I never would have pushed the boundaries that I needed to push to get where I am if that makes sense."
>
> **Ziya:** [resisting the cultural norms of obligation to marry, have children and 'settle down']
>
> "I can't really get told, oh you're not going to have a life, you're never going to settle down, you're not going to be able to do this or that"
>
> **Sarah:** "…so, nobody had any sort of influence in my decision to want to study medicine."
>
> ". the school was in quite a deprived area of the city" [and] was advertising something for getting into medical school, so I thought, well, I'll sign up for it"

All participants indicated their intrinsic motivation, either explicitly or implicitly, and although some parents may have provided a level of moral support for accessing university, these parents were not able to inculcate knowledge of tertiary education nor understandings of a career in healthcare, except for one student with an extended family member who was a nurse. In some cases, parents may have transmitted a sense of work ethic, but not the transmission of any familial knowledge of tertiary education, nor medicine.

In terms of the literature on transitions into HE and particularly students' narratives in my study, their agency and motivation to progress into tertiary education is not essentially derived from family members and knowledge that they convey to their children. Yet Bourdieu's theory has been the most often used theory to explore student transitions in medical education (Gore et al., 2018). Bourdieu's 'theoretical tools', Symbolic Capital, essentially the combined social and cultural capitals, e.g., 'who you know' and 'what you know', assume that these assets are formulated within the individual's family, school, or with others in their social milieu. My view is that this perspective, Bourdieu's socio-cultural reproduction paradigm, essentially accounts for disadvantage and inequalities, rather than positive qualities, and so does not align with my data. Yang (2013) considers that Bourdieu's most

crucial weakness in his theory is the inability to anticipate 'change', and further, the neglect of agency and individualism. Additionally, 'downward social mobility or down-classing' is not accounted for, which could be a possibility in social periods of economic depression. Thiele et al. (2017b, p.51) argued that a wider theoretical lens than Bourdieu's should be adopted to capture "diverse contexts and frames of reference within which young people are operating".

The assumptions seemingly made in many studies exploring why some underrepresented students in HE, including those who choose not to access undergraduate education, were the inadequacy or absence of possessing social and cultural capitals, as defined by Bourdieu (1973). As a consequence of not possessing those capitals, individuals have often been perceived, within some of the previous research such as the work of Reay et al. (2009) and Nicholson and Cleland (2017) as being in deficit, due to not having been afforded the crucial, 'normative' capitals to progress into and through tertiary education. These capitals or assets are assumed to have been transmitted by the family or possibly social associates of the family, where advantageous connections are made.

However, there is a possibility that learning experiences which could afford some level of advantage in pursuit of a medical career, may not always be initiated through the family channel, but opportunities for networking or mentoring could promote opportunities for personal development. Contacts with a range of people are possible, and from the findings have proved very beneficial for some participants. As previously mentioned in my narrative analysis, participant Sarah contacted a cardiologist via a friend with whom she attended a weekly dance class. In another case Aura was mentored through the charity, In2MedSchool (2024) to gain support for understanding the process for accessing medical education. Social mobility has been viewed through a paradigm of support rather than deficit, where agency is a central feature, and the valuing of individual self-determination is more valid (Ryan and Deci, 2000). Although Self-Determination Theory has been criticised for relying on an outdated intrinsic/extrinsic motivation dichotomy, and the possibility where an internal barrier of self-coercion may arise if an individual assimilates a stigma which is placed on them. Despite these criticisms, I consider that there is value in the types of motivation to determine if there is a distinction between the two in practise.

I propose that the juxtaposed perspectives of 'Free-will' and 'Determinism' are useful to employ when considering the appropriateness of theory and research to explain the nature of transitions into HE. Theories underlying social determinism, and the tendency to proliferation of social stability, contradict the possibilities for social justice and directives for social change. Bourdieu's theoretical framework, being socially deterministic, is limited and therefore does not serve the needs of social justice, where a positive perspective in valuing the individual and personal attributes, is more valid.

Agency, in a 'free will' and individualistic context, might be defined in different ways, and the definition I chose to use (Chapter 4) is one of Spencer and Doull's (2015, p.904) concepts of power, where an individual's personal mastery and control over events and actions, e.g. development of own self-esteem and self-efficacy beliefs. For example, halfway through her first year of A level programme, Liz wanted to change from studying Music to the Sciences, but her father and his side of the family were very disapproving of her wishing to change. This exemplified a dilemma between internal and external motivation, and on reflection she told me that she did not have anyone to guide her because no one in her family had done anything educational because of their working-class, manual jobs. However, Liz's long-term partner, who was qualified to post-graduate level, and whose family were highly educated, provided her with a level of intrinsic motivation. Despite the pressure from her family, Liz changed from music to the sciences, which completely changed the course of her life.

Distinguishing between the nature of motivation and impact on transition may not be simple, with the variations between everyone, changing social contexts, and the degree to which learners perceive they are in control of their own life. Transition should be viewed as both idiosyncratic and socially contextualised. Olivia had remarked that she was curious and was self-curating an idea of professionalism. Ellie, also regarding herself as curious, and responding to the lack of support from the school for accessing medical schools, personally accessed the websites of two universities and attended their summer schools between the two years of her A level programme. For both Olivia's and Ellie's use of the word 'curious', I am taking this to mean an agentic tendency to be intrinsically motivated to explore.

Self-regulated learning

Self-regulated learning is inextricably linked and underpinned by agency and intrinsic motivation, with a clear focus on the personal, with Liz considering herself to be an independent and self-regulated learner. Olivia indicated she was always academic, really enjoyed studying, and later commented that she completed 30 MOOCS during the Covid-19 lockdown period, and the Year 1 of her undergraduate programme.

As independent learning is an expectation of student capability for learning within the HE sector, I noted from the FiF students' narratives, the skills they brought with them to the medical school included a capacity to work independently and progress from their point of access and progression through the early years of medical education. The findings indicate that students from FiF backgrounds possess skills and attitudes for success in the undergraduate programme, contrary to those studies which use Bourdieu's form of theorisation, which expounds expectations of deficit and

the need to 'top up' new learners from underrepresented backgrounds, when they first enter HE institutions. Another perspective, such as Yosso's (2005) model, offers other capitals which are potentially more diverse and inclusive. By applying the model, O'Shea (2016), gives credence to students' lived experiences. Some of these assets are demonstrated in the narratives of participants from my study and indicate how FiF students might develop learning skills that are not necessarily transmitted from the position of privileged family culture. This was expressed by Ziya who considered that she had always been an independent learner and doing everything for herself, because of the way she had always lived and her parents not speaking English. Loki too, approximated the time when she thought the regulation of her learning began, considering it to be the early part of secondary school,

I have learned from students' narratives where they account for their type of learning in specific ways, particularly the period when they thought their independent learning style commenced. A couple of examples above indicate where participants recall thoughts on becoming an independent learner, in some cases from being spoon fed to agentically searching for knowledge and studying independently. Although I have linked the process of self-regulated learning to agency and intrinsic motivation, I recognise that students are learning in a social context, within a discipline and practice organised by a curriculum. Students are not learning in a vacuum, but in a social setting.

Jarvis' (2006) model provides a useful tool to focus on the inner and outer worlds of the learning process in capturing the relevance of the potential variance in the social setting of the learning experience for each learner (the outer world) and the subjective interpretation and processing for each student (their inner world). The FiF students' inner worlds have been represented through the reflective, narrative accounts in the data, where they have recounted specific events in their outer world. I propose that the transition experiences include a metacognitive process, whereby students will focus and monitor a learning task, which may be new knowledge or a skill, and internally assess their personal level of success. This perceived level of success will register in self-efficacy belief terms and transform personal identity. Jarvis' (2006) nuanced model of learning expounds the complexity of the learning process, with the particular person in their 'life-world' becoming a 'person-in-their-world changed. Between the beginning and the end of a specific learning encounter is a transitional period where, I would suggest, the learner perceives a transformation of identity, an identity of becoming a doctor.

Reflexivity and self-authorship

I propose that transition experiences include a metacognitive process, a process facilitating the students' personal capacity to learn about themselves, their mode of learning, and how they are

changing over time. Olivia's narrative which suggested she was self-curating her understanding of professionalism, is indicative of a socio-cognitive process and constituent element of becoming a doctor, which is representing the personal meaning-making of one's own transition. Brown (2022) suggests that our subjectively construed identities are the meanings that we attach reflexively to ourselves. Additionally, he acknowledges the work of Petriglieri et al. (2019) stating that "identities are important, not just because they make people's inner and social world's intelligible, and manageable" (Petriglieri et al., 2019, cited by Brown, 2022, p.1206), and then Brown continues to say "but because, more significantly, they are a means by which we render our lives meaningful" (Brown, 2022, p.1206). Meaning-making is a crucial aspect of our being and becoming (Van Manen, 2016, p.7) forming and reforming our identity through our transitional journey.

My proposal is that self-curation, self-formation and self-authorship are suggested (sometimes implicitly) in several reflective narratives, suggesting the students' awareness of being agentic and self-aware of how they wish to progress. With regards to the development of professional identity and clinical skills, and 'becoming a doctor', within the transitional process, it was pertinent to consider narrative evidence in the students' accounts, which might be regarded as both radically transforming and indicative of them being actively involved in their own development (Nordenbo, 2002, p.341). In this sense I highlight the degree to which I became aware of students' deep reflection in their narratives and, to some extent, the emergence of, and showing reflexivity. Across the participants, often there were references made to critical meaning making and understandings of their metacognitive becoming.

In considering students' personal experience of transitioning into and through medical education, with the assets they possess individually, the other philosophical and theoretical position I wish to offer is the concept of Bildung, a German word which encompasses an individual's active involvement of self-formation (Nordenbo, 2002; Van Manen, 2016; Koller, 2020). The construct of self-formation in Bildung, for me, has a link to the domain of the inner world, part of Jarvis' model and by extension to 'self-curation', which was used voluntarily by Olivia: "I think in my head I kind of curated this idea of professionalism and altered it to fit me because in my head, I kind of still see myself as a student."

Koller's redefined concept of Bildung, was to align with the conditions of current social times, and conceive that "interaction between subject and world as the subject's response to new challenges posed by its environment", and "…the way in which people interact with the world and relate to themselves is mediated by language" (Koller, 2020, p.635). I believe there is a need for self-reference

through a deeper form of reflection. This aligns with Jarvis' (2006) perception that feelings of unease or disjuncture trigger existential thought and moments of learning.

It is worth noting that Koller's (2020) new understanding of Bildung suggests two types of changes the individual might go through:

1. Learning processes characterised by absorbing new information or acquiring new knowledge and skills without changing the way information itself is processed or skills enacted.
2. Another understanding of Bildung, is a higher-level learning process where we not only acquire new content but also how we relate to the world, other people and ourselves, and are subject to radical transformation (Koller, 2020, p.636).

I propose that the second type not only aligns with Jarvis' model of the transformation of the person through learning, but also the existential thought processes of self-formation and self-authorship (Baxter Magolda, 2008). It is within this theoretical space, learning skills and knowledge, and the concomitant deep reflection on self, that subjective transitions are curated and maintained. The transition is where participants effectively create new knowledge of themselves.

Part 2.

Addressing research question 2: To what extent does the study contribute to the theorisation of transition?

Previous contested constructs of transition, outlined in chapter 4, and specifically Gale and Parker's (2014) third conception within their typology, 'transition as becoming', being of a dynamic and ideographic account of student transition, was a basic starting point for my inquiry. The authors remarked that this particular conception is "least well understood" and is, "yet to be fully expressed in HE research, policy and practice" (Gale and Parker, 2014, p.633). This led me to focus on an area of knowledge where there was a gap in understanding and theoretical application, relevant to participants in the study, medical students who were 'becoming doctors' through an academic degree and clinical training.

There was a sense that not only was there an opportunity for the participants to demonstrate aspects of the 'becoming' conception, but additionally subjective understandings, through the reflective narratives, of their ongoing transformations of identities. Additionally, I identified from the data that, if participants recounted subjectively perceived distinct and noticeable changes in identity, within their narrative accounts, we might view the transformational process in two ways. This may be either a distinct or definitive one, based on a movement from one status to another, e.g. from a 6th form student to a medical student (the two levels of education), or alternatively, it might be a

transition over a period, for example learning during an academic module in the undergraduate programme, or gradual exposure during a specific clinical placement.

Liminality is a useful concept for consideration, not only regarding the theorisation of transition in HE generally, but also specifically when we examine the micro level of human experiences (Rutherford and Pickup, 2015). When students are within the higher educational transitional space, they are in-between positions of knowing and becoming, and possibly with feelings of uncertainty or ambiguity. Southgate et al. (2016) referred to in the Review of Literature, Chapter 3, mentioned that students were working through the ambiguity of fitting within a new middle-class dominated culture. Medical students may feel they are becoming a doctor, but there are several liminal thresholds to cross along the journey. The thresholds are the noticeable points in the transitional process where the student is aware of how they have changed.

Transitioning towards becoming a doctor

Experiential transitional changes reformulate students' meaning frame and a subjective shift in identity (Rutherford and Pickup, 2015, p.703). The transition of becoming resonates with Gale and Parker's (2014) concept, mentioned earlier, but I consider that now the findings indicate that the concept is much more nuanced. Not only is the perception of transition and subsequent impact on identity transformation subjective, the shift in identity in some instances may be more gradual and less perceptible, whereas in other examples, it could be more obvious and instantaneous. The perceived rate of change in identity, in the context of student experiences, might be variable across the participants, which, in part may depend on the variety and timing of the academic and clinical training experiences available to them, and the interactions with different tutors and clinicians. Specific, timely opportunities in some cases, might provide critical moments to develop their understanding or skill in a particular domain. Some critical points where transitional change and feelings of 'becoming a doctor', were clearly demonstrated through transitional curations in the minds of the students. These contexts and transformational moments are recalled in the exemplar reflective narratives below:

- Taking blood
- Communication Skills, and
- Being on Clinical Placement

Taking blood:

Sarah's account of taking blood successfully on three consecutive occasions, was an example of the impact of clinical skills and knowledge development. This was a step in the perception of becoming a doctor, where a specific self-efficacy belief led to a definitive change in Sarah's identity. It was particularly noticeable with one of the patients, when the phlebotomist was engaging the patient in conversation while Sarah was undertaking the task. The bloods had been taken and placed in a tray away from the view of the patient, who then said, 'When are you going to do it then?' Sarah used this experience as self- acknowledgement that she could take blood successfully in respect of a new skill acquisition. She curated a self-efficacy belief which changed her knowledge base and transformation of identity. This specific example of transition and transformation of identity was a more instantaneous one due to the immediate feedback from the patient.

Communication skills:

Olivia, on a placement in primary care received feedback for her excellent communication skills with patients, greatly increasing her confidence and affecting her identity. She remarked that she was self-curating an idea of professionalism, which I take her to mean a personal understanding of the professional expectations in medicine, prescribed by national and institutional stakeholders, and her personal 'take' and adoption of the criteria. This identity work, which students will be continuously embarking on, could be motivated intrinsically or extrinsically, or a combination of the two. In this specific case, the feedback was given by her supervisory GP.

Participants generally believed that their development of doctor-patient communication skills developed gradually, at a slower pace, but their exposure to members of the Patient and Carer Community (PCC) sessions, within the undergraduate programme accelerated self-efficacy beliefs in this skill developing space. Members of the PCC are patients or carers with a variety of conditions and experiences who volunteer to work with the medical students at various points throughout the undergraduate programme

Being on clinical placement:

There was a tendency for the students to reference the relevance of their clinical placements as critical points in their transitional change. Theo remarked that, "going on placement and actually doing things that a doctor would do, makes you feel like going to be a doctor, actually makes it feel more real."

Inviting Theo to consider a particular point in the academic year which has given her confidence in the execution of a specific competence, she replied, "The first time I had a consultation with a patient, being able to lead a consultation." The consultation had taken place in a GP practice. Asking

Theo if she reflects on her transitional process, 'how it is going', 'how she is feeling, and where she is now' her response was, "I think it is something you have to do, because you are aware that it is a very big step, and you are definitely changing as you go along … you need to do it in the medical field and keep track on how you are improving and how you are changing."

From the specific stories told within the two-year longitudinal study, there were many references to the curricular transition from Year 1 to Year 2, where exposure to clinical skills was more distinct in Year 2. With this cohort of students, it was a starker change in their geographical space, because of the severe Covid-19 restrictions on the programme during the entire Year 1. Understanding the derivation of personal change is useful to explore.

What instigates considerations of identity transformation and individual perceptions of transition?

This question raises another question. Is it a consequence of the interview questions which prompts this capacity for deep reflection in the students, or could the process be instigated independently, through personal student volition and aspects of metacognition?

I consider that perceptions of identity change will occur when either individuals engage with metacognition of their own accord, or when the self-reflection is triggered dialogically through academic or student support sessions, where students need to respond to questions posed during active involvement in the academic curriculum, or in these interviews. Student reflections on why they personally valued the interview process was outlined in the latter pages of Chapter 7, which supports my theorising that the dialogic process is beneficial for FiF students embarking on medical education. The implications for beneficence arising from adopting this form of dialogue in student support is discussed in the next chapter. However, it must be remembered that there was also evidence that the participants reported their additional and continuing reflection with peers, parents, or a partner, outside the confines of the research process. It could be that their motivation to engage with reflection is a result of being introduced to this practice as a requirement of the medical profession, outlined by the General Medical Council (2024).

Nonetheless, the students would frequently reveal their general reflective thinking and meaning making about the nature of transitions and perceived transformations in their identity, as an integral part of the research interviews. For example, through her deep reflections and wide-ranging lived experiences, both academic and care-giving situations, Olivia was aware of how she had changed, 'In a good way', she added. In her later story lines in the second and third interviews, she would always refer to the central position of reflection. Sarah too, demonstrated the ability to reflect on her

ongoing transition to keep herself 'on track', which indicated how she was considering her transition over time.

A distinctive view on identity was that of Loki, by her feeling, "…I just don't really have a proper identity … it's like a broken identity." When teasing out her meaning of "broken identity", as possibly being 'in bits and disjointed', or that she was 'still forming her identity', she replied: "It was a bit of both." She was trying to figure out her identity and the elements where she had formed it. It appeared that metacognitively, she was objectively making a determined effort to make sense of this aspect of her self-perception. Underpinning her perception of having a 'broken identity' during the two interviews in Year 1, her disclosures of mental health issues seemed to be a consequence of her continued willingness to help peers and members of her extended family, as and when they requested. This was to the detriment of her own studies and her limited availability of time, and probably an absence of 'care of self' (Infinito, 2003, p.157).

Deontologically and accounting for my ethical obligation to participant wellbeing during the research, my immediate response after this interaction with Loki, was to check if she had accessed mental health support. She assured me that she already had, along with other students in her circle of friends. When we consider 'care of the self' within self-formation, in the context of implications stemming from this research, this aspect must be part of any formulation of student support. I return to this crucial aspect of transition and transformations of identity in Chapter 9, particularly in the way "students engage with forethought and reflection which can result in deeper, more meaningful learning" Ritchie (2016, p.71).

The narrative accounts in the study have indicated personal reflections on elements of transition through agency and self-efficacy beliefs within ongoing skills and knowledge development. With Olivia adopting the construct of self-curation, I considered whether other participants in the sample indicated thoughts on an idea of self-curation, or comparable constructs, within a personal process of transition and professional identity formation.

Ellie essentially outlined how she applied her skills of free association thinking, examining thoughts and words coming to her mind, demonstrating a capacity for metacognition, and interrogating her own being. In other respects, it would seem that Ellie showed aspects of self-authorship (Baxter Magolda, 2008), which is demonstrated by other participants in this longitudinal inquiry. 'Self-authorship is a capacity that allows young adults to better meet the challenges of adult life. "Reflective conversations in all arenas of the college experience can also draw out and support students' internal voices" (Baxter Magolda, 2008, pp.282-283). In research terms, there are key

lightbulb moments when students are looking at transitions themselves, alluding to reflective and metacognitive processes.

I propose a construct of transition, based on findings from this study as:

A Personal and Subjective Transformational Process, represented by multiple and ongoing transformations of identity, founded on reflection and metacognition.

Part 3.

Addressing research question 3: Are there any implications for how medical schools might support these transitions?

I would argue that in a developing world of inclusion, within the context of widening access and fostering social mobility for FiF individuals, we should think in terms of what each student brings to the medical school, and not potential weaknesses. In essence, we should not give any credence to the idea of students entering medical school in deficit, when to the contrary, they may have much to offer. They may have been socially disadvantaged but are advantaged in many other ways.

It would be useful, in supporting medical students' understanding of their developing identities, and facilitating smooth transitions, to consider personal aspects of how they perceive themselves, their being, but also how, through becoming, their being might change over time. In essence, it is a recognition of when and how they changed, and possibly the point when they changed thinking about themselves. How they are now, but also how they might wish to become, and the comprehension and internalisation of becoming, a composite process of personal and professional development. This would not only be crucial for academic and clinical development, but also in respect of constructive, ongoing transitions in mental health and wellbeing, perceived as Foucault's 'care of self' (Infinito, 2003, p.157).

Initially, my purpose and intention was to focus on the construct 'transition', the phenomenon under study, and specifically the personal transition of each participant, I deemed it appropriate to underpin my philosophical base (Chapter 5) in a framework of 'hermeneutical phenomenology' (Gadamer, 1970; Ricoeur, 2008). Gadamer (1970, p.157) and Ricoeur (2008) all have specific directives on the relevance of dialogue to facilitate a close connection with personal lives, as well as Van Manen's (2016) focus on the ability to be conscious of ever-evolving lived experiences. This position foregrounds the focus on the individual's lifeworld and existence explored by their meaning-making. Practically, I realised this would be achieved by homing in on the individual's story and the

changed person, by respecting and exploring the idiosyncratic perspective of the first person. To access each student's lifeworld and lived experiences, with minimal direction from me, the semi-structured interviews were purposely conducted as informal conversations (Chapter 5). The principal was to employ an open, sensitive and trustworthy procedure, to not only put the participants at ease, but also to supportively engage them in a continued willingness to embrace the requirements of a longitudinal study over two years. The implication for education is to foster reflection and metacognition.

In the context of the methodology and relevance of reflexivity I expected to be embedded in the study, I had disclosed my identity to the participants and shared that I was not a doctor, was the first in my family to undertake a degree and taught on one of the modules in their programme. Earlier in the three interviews some of the participants had remarked about their enjoyment of the module that I had taught, and I consider that these connections permitted them to feel at ease in their personal revelations during our conversations. At an earlier stage of the research, I did not consider myself as an 'insider', but on reflection with my supervisor I began to realise that I was an insider, or at least a peripheral member of their outer world. Therefore, a reflexive approach at all stages of the study was required to ensure credibility of the data, which I previously referred to in Chapter 5, Philosophy, Methodology and Method.

These methods that I used reflexively for data collection and analysis, made visible:

1. Self-Formation
2. Self-Authorship*
3. Agency
4. Self-Regulated Learning
5. Metacognitive forms of reflection

These are part of their transition process which they bring as their comprehension and contribution to a revised theorisation of transition. The methods could be translated to education, and application of these ideas will form the basis of suggestions for developing institutional support for FiF students in the Recommendations section of the final chapter.

On the strength of the findings from the data, including the preferences indicated by the students in the sample, I propose that medical schools should consider generic ways of supporting students. This could be developed through a form of dialogic mentoring, to develop skills of deep reflection for medical students to self-monitor the strands of transition within the overarching points 1-5 above. The principal requirement would be to facilitate and capacity build skills which have been demonstrated by the participants in this study.

*Note: Kegan defines self-authorship as the shift from meaning-making capacity from outside the self to inside the self (Kegan, 1994, p.185), a focus on free will and not determinism from external pressure.

9. CONCLUSION

Conclusion of Findings, Benefits, Limitations, and Recommendations

This chapter encapsulates the principal elements of the discussion and benefits of new knowledge gained from this inquiry. This is followed by the potential limitations of the study, which are addressed in the context of the methodology adopted and guarding against researcher bias. Finally, but by no means less important, are implications for the adoption of educational directions for future student support and further research in this crucial field of promoting equity and inclusiveness in medical education and healthcare services.

Conclusion of Findings

The idiographic approach and micro-level analysis indicated unique and personal transitional experiences of each student, specifically changing their perceptions of their identities. Transformations from learning about academic knowledge and skill development were augmented by learning knowledge of themselves. This knowledge of self was particularly appreciated by the participants as a means of understanding academic and professional development towards 'becoming a doctor.'

Methodologically and reflexively, I continually focused on a need to ensure that despite working closely with the participants to gain reliable and trustworthy findings, I remained conscious of the interaction between my researcher position and that of each student. Our two independent worlds, coming together as our independent realities are shared through dialogue. Figure 4 below indicates a constant reminder for me to ensure continuous reflexivity in pursuit of ongoing trustworthiness of the process and data, specifically around the representation of truth.

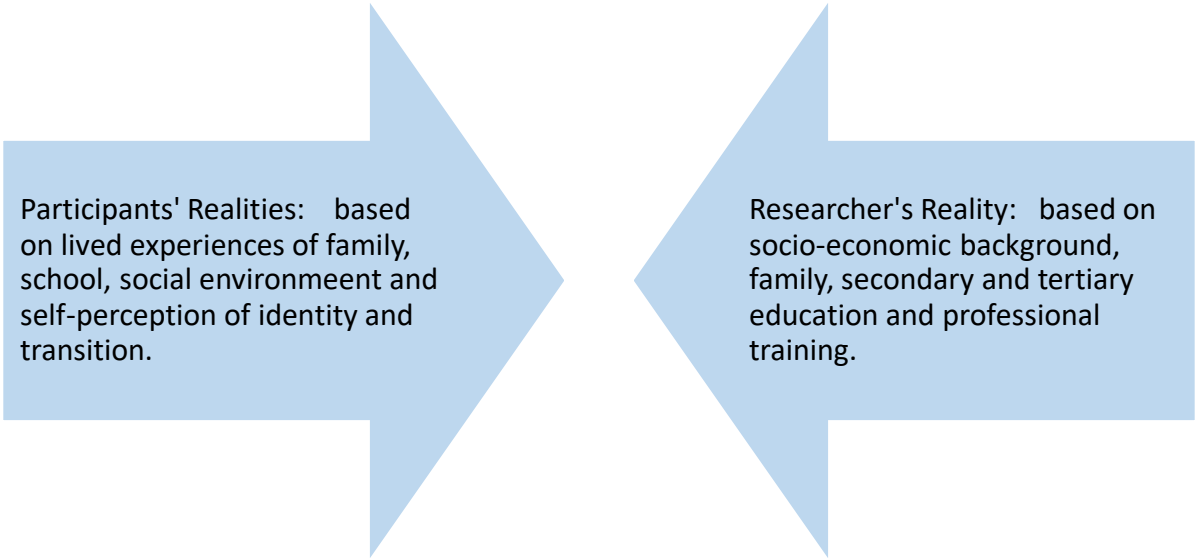

Figure 4. Whose truth is it: The interface of participants' and researcher's worlds?

As the researcher for this inquiry, I began with my epistemological and ontological assumptions but was aware that caution should be continuously present to ensure that the knowledge of my world, both past and present, should not impact negatively on the subjective design of the study nor the analysis of the data. This was a difficult thought process in attempting to safeguard against possibilities of bias and simultaneously enhance the study's rigour. Constantly, thinking of my own culture, family and educational experiences, I recalled them to ensure that I avoided knowingly transferring my personal values onto the voices of the participants during both the interviews and subsequently during the analysis of data. I have used an active voice to explain justification for procedural actions and interpretations of participants' self-perceptions in their narrative accounts. An example of this was the use of 'dependability checking' of the participant's transcript which was forwarded to all of them shortly after transcription of the interview recording (Varpio et al., 2017, p.46). The intention throughout the study has been to privilege each participant's voice and, wherever possible, the meaning behind their narrative account.

The constructionist ontology of the study focused on my belief that multiple realities exist, realities which depend upon social interactions between an individual and their social world. The social world exists through dialogue, and the principal mechanism for articulating reality, or a particular truth of reality, is through discourse. Consideration of the two independent worlds of participant and researcher were crucial to ensure that my personal position in the research did not obscure my subjectivity and involvement in the interpretive process.

Benefits of the study

The principal benefit of the study, compared to previous research in the field of disadvantaged students accessing medical education, was the level of preparedness shown by the participants, particularly self-regulated learning, depth of reflection and understanding of identity transformation. These were existing assets and specific strengths of WP/FiF students on entry to the institution and the ongoing transitional process, which challenges the deficit model propounded by other studies in the field. The study therefore addresses a gap in literature and adds to the limited body of previous research.

A further benefit of the study was the desire of the participants to engage with an opportunity to engage with reflection to discuss transitions and changes in self-efficacy beliefs and identities.

However, we cannot assume that socially advantaged medical students do not possess other pressures, e.g. from privileged family members to perform well in education; pressures which might have implications for their mental health and wellbeing. In this sense, an improved tutoring system may be a benefit for all medical students and not merely FiF, first generation students. All medical students need more creative solutions for developing reflective practice, not just the perfunctory and routinised reflections for clinical and professional performance requirements, but also the crucial reflections for self-formation and self-authorship.

Limitations of the study - addressed

Potential limitations which might be levelled at the inquiry could be the single-site location of the research and its distinctiveness of cohort, compared to other medical schools, and the possible volunteer bias regarding a single gender sample. The choice to use a first-in-family selection criterion for the sample may not have been representative of all previously underrepresented students accessing undergraduate medical education. Beyond the control of the longitudinal study, the first year of data collection was potentially impacted by the Covid-19 restrictions. The design, collection and analysis of data has been undertaken solely by me; the researcher. These potential limitations of the study are addressed as follows:

Case study in a single school of medicine:

In addressing these points, research has been undertaken in the field of widening access for underrepresented students across all UK medical schools (Medical Schools Council, 2023) indicating WP progress achieved from 2020-2023. A 10-year report for 2014-2024 is to be published by the Medical Schools Council in December 2024. Whilst all 44 UK medical schools have made progress in

widening access, this study has focused on students' unique perceptions of their transition in a particular medical school and through the early years of the undergraduate programme.

Single gender group sample / volunteer bias:

The all-female sample was formed by self-identification and volunteering as FiF students, and subsequently some indicated they were personally interested in taking part in the study. However, in the site of the study, there is a tendency for the female to male student ratio each academic year to be around 2:1, it was anticipated that there would be fewer male student volunteers. Volunteer bias in the context of this inquiry has been a positive one, with some participants indicating their reason to be involved with the study and subsequently what they personally gained from taking part.

Representativeness of FiF sample for underrepresented groups accessing medicine:

The single FiF criterion for sample selection, in respect of other criteria for 'contextualised admissions', was purposely used to avoid potential reluctance of participants to disclose other factors about their personal or family demographics. However, it was subsequently revealed by students' disclosures about their intersubjectivities, which transcended the other contextualised admissions criteria; possibly ethnic heritage, unemployed parents receiving benefits, or residency in a disadvantaged geographical area. Subsequently, the revelations indicated there was a wide range of demographic indicators among the sample of eight participants, which would nullify underrepresentation of the sample.

Data collection during the national Covid-19 restrictions:

The Covid-19 restrictions during their first year of the undergraduate programme; the initial year of the longitudinal study, impacted marginally on all participants in a similar way. In-person social interaction was restricted, though they regularly interacted on social media platforms for both social and academic purposes. Some participants remarked during the second interview at the end of Year 1, that they missed being on the campus and were looking forward to the beginning of Year 2. There was no impact on the study itself during the Covid-19 restrictions, and despite the two online interviews adding to the required online learning commitments during Year 1, the participants regarded our conversations as welcomed breaks in their schedules.

Study design, data collection and analysis were undertaken by a single researcher:

Although I was the single researcher for this study, the advantage of this was to ensure consistency in the format and conversational style of the interviews over a two-year period, and additionally ensuring reflexivity throughout, and consistency of the narrative interpretation.

Recommendations from the study:

I am presenting my recommendations from this inquiry in two parts, firstly to consider valuable indications from the findings regarding the implications of the theorised conception of the transition process for previously underrepresented medical students. Secondly, to consider the use of efficacious support strategies for students which were illuminated in the participants' appreciation of their deep reflections being facilitated during interview conversations. Appropriate support for WP medical students throughout their undergraduate studies will maximise opportunities for them to feel a sense of belonging to the school of medicine and to reach their full potential.

Part 1: Transition as a personal reflective process and the Institution

Based on the understanding that all students' transitional journeys are unique and varied, it is crucial that an inclusive learning environment is fostered within schools of medical education (HE Professional Team, 2023). Institutions "can empower underrepresented students to reach their full potential and contribute to a more diverse and inclusive society" (2023, p.2), with each student bringing their own unique dynamic to the situation, Ritchie (2016, p.21). To contribute to a more diverse and inclusive society, the institution (school of medicine) would need to ensure the culture, procedures and practices are inclusive. In terms of the expanding inclusivity in schools of medicine with the increasing number of previously underrepresented students accessing medicine, there is a need to consider the doxa of the institution. Williams (1997, pp.24-46) suggests that some institutions (schools and universities) may have discourses which form a doxa that might mask symbolic capital which sustains some social positions and closes down access for others. Beyond the level of access, there is a need to ensure that the curriculum and the delivery of the curriculum is regarded as 'fit for purpose' in regard of supporting students from different backgrounds and with different capitals, some of which might be those suggested by Yosso's (2005) model.

Recognising the possibility of a diverse range of students accessing the undergraduate medicine programme, and the recognition of the need for inclusive and equitable provision within HE institutions, the study indicates that the unique personal capabilities of all students should be both appreciated and accommodated.

Part 2: Support of the personal reflective process

The eight participants at some point during the study remarked on the value they placed on having learned more about themselves during, outside and beyond the interview, instigated by the interview conversations. This evolved through a self-reflection process of deeper engagement with

their identity and transition. At one point, I had outlined to them the ancient Greek Philosophers' maxim or axiom to 'Know Thyself', as a means of exploring their understanding of deeper reflections on being a medical student and becoming a doctor. This led me to focus on any narrative evidence which suggested self-reflection, reflective practice, and any aspects of self-formation. All participants explained in detail the value of the longitudinal interview process as a supportive reflective opportunity to make sense of their own transition.

Towards the end of the third interview in Year 2, awareness of the participants' considerable appreciation and value they voluntarily placed on the conversational style of interview was consolidated. These perceptions encultured a deep reflective process for storying their transitional journeys and implications for identity transformations. Subsequently, I decided to augment the data through a study following the end of the Year 2 programme by inductively following the cue offered by the participants. My intention was to facilitate a short data collection between the 2nd and 3rd academic years, so as not to impinge on the commencement of the Year 3 programme. I applied to modify the ethics approval, which was granted at the end of the participants' second academic year. The invitation for participants to take part in an additional piece of work was an email request that they create a maximum one-page reflection on their thoughts on the informal dialogic process in the interviews and the value for their ongoing transition. The participant information sheet for this supplementary study is provided as Appendix 5.

This additional data helped me to explore how they came to reflect on, and appreciate, their own transformations and transitional journeys through medical education up to that point in time.

Following analysis of data, it appeared that their considered beliefs about the efficacy of the dialogic approach employed in the interviews were a substantial benefit to them. The supplementary study revealed that not only were many of their reflections deep, substantive, and at times very profound, they also appeared to be extremely efficacious for self-development and understanding of both identity transformations and meaning making of their personal transitional process.

Embodied in the concept of self-authorship, Baxter Magolda (2008) emphasises the nature of students' internal capacity to 'define one's own beliefs, identity and social relations' (2008,p.269). Principally this constitutes a shift of meaning making from outside the self to inside the self, with the individual becoming the coordinator of defining her or his beliefs and identity (2008, p.270). This capacity provides the opportunity for students to create and review their own ongoing changes in identity and, I suggest, their own personal transition over time. In the reviewed studies by Baxter Magolda, she indicated that self-authorship was possible and evidenced in the late teens and early 20s.

A critique of self-authorship, acknowledged by Baxter Magolda, is one of egocentrism, “a focus on the self, rather than on relations with others” (2008, p.271). Examining the later work of Foucault, Infinito (2003) outlined Foucault’s ‘ethical self- formation’ (uniting individual agency with ethical consideration). At one level, it is possible to counter the critique of egocentrism in Baxter Magolda’s work and give credence to, and a higher recognition for the construction of the self, if we plug in Foucault’s conception of ethical self-formation, where he considers that the ‘formation’ involves ‘care of the self’, an aspect of personal freedom - a creative and productive human freedom which depends on how we act with others Infinito (2003, p.157). He believes that our ‘selves’ are harmed when we subjectively are not involved in our own construction. His position is that ethics is about the subject’s own life and her or his thinking about that life, and not merely obeying fixed moral dictates (2003,p. 160).

This view of self-formation extends beyond the familiar Socratic dictate of ‘knowing yourself’ which I referred to previously, though this self-knowledge is a necessary starting point for reflective practice. Foucault remarked that care for oneself is integral to a range of doctrinal teachings, e.g. medicine, politics and education, which I suggest is clearly relevant to medical education.

In support of facilitating the personal reflective process, as the vehicle for efficacious transitions in medical education, I suggest that the educational programme should include a tutoring mechanism to facilitate students’ self-formation of identity through a dialogic process which recognises their agency and competency for deep reflection and learner reflexivity. An essence of this study was that of identity, how the students recounted various aspects of their identity in disclosing their early life experiences prior to accessing undergraduate medicine and then subsequently their transition through the first two years of the degree programme. Much identity work has been undertaken and demonstrated by the participants; I propose that a medical education curriculum should have a built-in facility to encourage medical students to reflect on their self-formation and take an active part in making meaning of their identity. Indeed, van Zoonen (2013, p.44) remarked that “…identity is something that we do, rather than something we are.” Similarly, Wortham (2001, p.157) suggested that “autobiographical narrators establish a coherent sense of who they are.” Jarvis (2006, p.120) in referring to hermeneutic thinking and the meaning that we give to experiences, “underlies our narratives about ourselves.” Narratives about oneself involve identity work, where the individual makes meaning to how they have changed, and in what ways.

I propose that it is necessary that schools of medicine should facilitate opportunities for students to discuss their transforming identities as an integral part of their ongoing transitional journey to becoming a doctor. From the point of view of learner-centredness, agency, and the whole range of

'self' concepts, and in terms of some statements in the literature e.g.: "The only thing that holds you down is yourself" Ball et al. (2020) and "The only person who can help you is yourself" Reay et al. (2009, p. 1107), there is a need to empower medical students to appreciate how they might understand and accommodate their own unique transitions through undergraduate education and training, and beyond.

The agency demonstrated by the participants in this study was an active preference to have in depth conversations about their life experiences and progression through their personal transitions, should contribute to future discussions about how students might be effectively supported through their transition of becoming a doctor. This is underpinned by the research findings which suggest that:

- Students value learning more about themselves and their transitional process metacognitively.
- A dialogic approach is beneficial in supporting personal and individually nuanced transitions.
- Academic and personal tutoring could facilitate deep reflection and be a crucial strategy for all medical students (not solely FiF and WP students).

I now turn to what I believe are the principal implications and future directions for medical education.

Recommendations for changes to policy and practice for supporting medical students' transitions

This study uncovers valuable insights into the experiences of previously underrepresented students in medical education, revealing that these individuals possess distinctive personal qualities that enable them to navigate the challenges of the undergraduate programme with resilience. Moreover, these students exhibit a remarkable ability for deep self-reflection and the active curation of their evolving identities.

Considering these findings, it is crucial for medical schools to foster an environment that supports and empowers students through tailored mentorship and guidance. I believe that a policy which reimagines a personal tutorial system promoting a learner-centred approach to individualised self-formation and self-care, institutions can facilitate more effective transitions not only for FiF students but for all medical students. Such initiatives would have far-reaching benefits, enhancing the development of future medical students, enriching the process of becoming a doctor and improving the healthcare system for the future.

Where to next, following the completion of the study?

Two suggested directions for the future:

Direction 1:

I believe that to my knowledge this field of research has not surfaced previously in the field of medical education, and it would be useful for others to consider progressing this work, perhaps in the final years of the undergraduate programme. Such an initiative could be promoted by my submission of papers to relevant journals or present the study findings at national and international conferences. It is possible that this fertile area has a great deal to offer the transition of underrepresented medical students in the context of social justice and the current focus on equity, diversity and inclusion.

Direction 2:

In the context of redefining curricula and personal tutorial systems, I consider the time is opportune to broadcast and utilise the findings from the study to inform the way we support FiF students and their capacity for reflection.

10. APPENDICES

Appendix 1. Letter of permission to recruit from Gatekeeper

Outlook

Re: PhD Research

From Jason Ward <K.J.Ward@leeds.ac.uk>
Date Tue 11/17/2020 7:24 PM
To Kenneth Hargreaves <K.Hargreaves@leeds.ac.uk>; Anne-Marie Reid <A.M.Reid@leeds.ac.uk>

Dear Ken

I am happy to grant gate keeper permission to year 1 MBChB students for the purpose of the study.

Best wishes
Jason

Dr Jason Ward
MBChB Programme Lead
Honorary Consultant in Palliative Medicine, St Gemma's Hospice

Appendix 2. Recruitment video

This video features Tobias Mill, a 5th Year medical student at Leeds University, who reflects on his transitional experiences through the MBChB (Mill, 2020):

> Mill, T. 2020. *Tobias Mill - transition as ongoing lived experiences*. [Podcast]. [Accessed 10.12.2020]. Available from: https://youtu.be/Q9jDsvHXrDA?si=qm5BsmjG-raXSkNb

Appendix 3. Participant Information Sheet

UNIVERSITY OF LEEDS

Participant Information Sheet

Study Title: Experience of Transition in the Pre-Clinical Years of Medical Education.

This study has been reviewed and given a favourable opinion by the School of Medicine Research Ethics Committee on 02.02.2021, ethics reference MREC 20-028

Why have I been chosen?

You are being invited to participate in a research study: a personal experience of transition through years 1 and 2 of your MBChB undergraduate degree if you are the first person in your **immediate** family to study at university. It does not matter if your cousin was at university.

What is the purpose of the study?

The purpose of the study is to explore the personal and unique transitional experiences of students as they progress through the first two years of medical education'

How will I be involved?

You will be invited to take part in three interviews to 'story' your personal experiences of transition during the early part of undergraduate medical education. You will have the opportunity to read the transcript of your recorded interview and make any adjustments to your story as you think fit. In addition, you will be able to use your transcripts from the first and second interviews to continue 'your story' during the second and third interviews.

What are the possible benefits of taking part?

Participating students will have the opportunity to reflect on their learning and ongoing transition through their medical education. This could have the benefit increasing self-awareness and self-directed learning. Additionally, it might produce indications where student support might be enhanced for future student transitions. You will also receive vouchers at the end of Year 1 and Year 2, as a token of gratitude for participating in the interviews.

What are the possible risks of taking part?

Students are asked to give a little of their free time to partake in three interviews over Years 1 and 2 which will have some impact but otherwise it is not envisaged there will be any risks to you in taking part in this study. If you disclose any unprofessional behaviour during the interview, it may be necessary to escalate the matter to a supervisory team. If you became distressed during the interview, the interview could be stopped, and you would be offered appropriate support. This support can gained from your personal tutor or found via the Student Counselling and Wellbeing services on the Student Education Services website http://students.leeds.ac.uk/info/100001/counselling_and_wellbeing.

Do I have to take part?

Your participation in this study is entirely voluntary and deciding not to take part will have no impact on your undergraduate course or assessment. If you do decide to participate, you will be asked to sign a consent form before participating in the interviews.

Can I withdraw from the study?

You can decide to withdraw from the study at any point during the interview or up to 2 weeks after the interview, after which the recording will be transcribed, and the data stored. You will be consented before each interview, so you will be free to withdraw between the three interviews, though remembering that once an interview is transcribed and analysed your data will be stored anonymously and will not be retrievable.

Will my data be kept anonymous?

Yes, your name or any personal details will not be attached to your recorded interview nor to the transcript of your interview. A report will be produced following the research and it is possible that data may be shared with other researchers and included in future research publications but in all cases names or other identifying features will not be included. All the data and any quotations used will be totally anonymised.

To enhance your understanding of the study, please watch the short video below:

https://youtu.be/Q9jDsvHXrDA

This video features Tobias Mill, M. Res, a 5th Year medical student at Leeds University, who reflects on his transitional experiences through the MBChB.

Thank you for taking the time to read this information sheet. If you have any questions about the above, or any other questions you may wish to ask, please do not hesitate to contact me:

Ken Hargreaves, Leeds Institute of Medical Education.
Contact: k.hargreaves@leeds.ac.uk or 07840628070

Study Title	Document	Version	Date
Experience of Transition in the Pre-Clinical Years of Medical Education	Participant Information Sheet	2	17/12/2020

Appendix 4. Participant Consent Form

UNIVERSITY OF LEEDS

PARTICIPANT CONSENT FORM

Title of Study: Experience of Transition in the Pre-Clinical Years of Medical Education.

Researcher: Ken Hargreaves

Please initial the box against each statement that you agree with:

1. I confirm that I have read the participant information sheet version 2, dated 17.12.2022 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving a reason. Additionally, I understand that following a two-week period after the interview, data from the audio recorded interview, will have been transcribed anonymously and it will no longer be possible to retrieve the data. ☐

3. I understand that data collected about me will be anonymised and may be used to support other research in the future, may be shared anonymously with other researchers and may be used in academic documents following the end of the research. ☐

4. I agree to take part in the above study. ☐

…….	…….	…….
Name of Participant	Date	Signature
…….	…….	…….
Name of Person taking consent	Date	Signature

Study Title	Document	Version	Date
Experience of Transition in the Pre-Clinical Years of Medical Education	Participant Consent Form	1	18/11/2020

Appendix 5. Request for extension of data

UNIVERSITY OF LEEDS

Request for Extension of Data

Research Study:

Experience of Transition in the Pre-Clinical Years of Medical Education.

Researcher: Ken Hargreaves

It became clear in our discussions during the three interviews that you really valued the opportunity to reflect on your story of transition through Years 1 and 2.

Other than recounting your thoughts and experiences of specific moments, over the two years and times before you came to Leeds, you indicated considerable value in the 'process' itself. That is the process of having an informal dialogue, through in-depth reflections, to account for your progress, possible changes in identity and becoming a doctor.

I am keen to gain your thoughts on the **process** we were engaged in during our discussions, to facilitate deeper reflections and allowing you to be more introspective in your transitional journey.

If it were possible to write a short piece (maximum A4 page or less) during July / August, so as not to impact on the start of 2022-23 academic year, I would be most grateful.

There is no compulsion to do this, so if you feel that you can't or haven't got the time, that's fine. I am most appreciative of what you have done to date.

Ken Hargreaves, Leeds Institute of Medical Education.
Contact: k.hargreaves@leeds.ac.uk or 07840628070

Study Title	Document	Version	Date
Experience of Transition in the Pre-Clinical Years of Medical Education	Participant Information Sheet: Request for Further Data	1	30/06/2022

Appendix 6. Letter from Ethics Committee acknowledging approval

Outlook

MREC 20-028 - Ethics Application - Approval

From Kaye Beaumont <K.D.Beaumont@leeds.ac.uk>
on behalf of
Medicine and Health Univ Ethics Review <FMHUniEthics@leeds.ac.uk>
Date Tue 02/02/2021 11:20
To Kenneth Hargreaves <K.Hargreaves@leeds.ac.uk>
Cc Medicine and Health Univ Ethics Review <FMHUniEthics@leeds.ac.uk>

Dear Ken

MREC 20-028 - Experience of Transition of Medical Undergraduate Students in the Pre-Clinical Years of Medical Education

NB: All approvals/comments are subject to compliance with current University of Leeds and UK Government advice regarding the Covid-19 pandemic.

I am pleased to inform you that the above research ethics application has been reviewed by the School of Medicine Research Ethics Research Committee and on behalf of the Chair, I can confirm a favourable ethical opinion based on the documentation received at date of this email.

Please retain this email as evidence of approval in your study file.

Please notify the committee if you intend to make any amendments to the original research as submitted and approved to date. This includes recruitment methodology; all changes must receive ethical approval prior to implementation. Please see https://leeds365.sharepoint.com/sites/ResearchandInnovationService/SitePages/Amendments.aspx or contact the Research Ethics Administrator for further information fmhuniethics@leeds.ac.uk if required.

Ethics approval does not infer you have the right of access to any member of staff or student or documents and the premises of the University of Leeds. Nor does it imply any right of access to the premises of any other organisation, including clinical areas. The committee takes no responsibility for you gaining access to staff, students and/or premises prior to, during or following your research activities.

Please note: You are expected to keep a record of all your approved documentation, as well as documents such as sample consent forms, risk assessments and other documents relating to the study. This should be kept in your study file, which should be readily available for audit purposes. You will be given a two week notice period if your project is to be audited.

It is our policy to remind everyone that it is your responsibility to comply with Health and Safety, Data Protection and any other legal and/or professional guidelines there may be.

I hope the study goes well.

Best wishes
Kaye Beaumont
On behalf of Dr Naomi Quinton and Dr A Howard, Co-Chairs, Somrec

Appendix 7. Letter from Ethics Committee acknowledging approval of amendment

Outlook

MREC 20-028 Amd 1 June 2022 - Study Amendment Approval Confirmation

From Medicine and Health Univ Ethics Review <FMHUniEthics@leeds.ac.uk>
Date Thu 21/07/2022 12:21
To Kenneth Hargreaves [RPG] <umkh@leeds.ac.uk>
Cc Anne-Marie Reid <A.M.Reid@leeds.ac.uk>

Dear Kenneth

MREC 20-028 Amd 1 June 2022 – Experience of Transition of Medical Undergraduate Students in the Pre-Clinical Years of Medical Education

NB: All approvals/comments are subject to compliance with current University of Leeds and UK Government advice regarding the Covid-19 pandemic.

We are pleased to inform you that your amendment to your research ethics application has been reviewed by the School of Medicine Research Ethics Committee (SoMREC) and we can confirm that ethics approval is granted based on the documentation received at date of this email.

Please retain this email as evidence of approval in your study file.

Please notify the committee if you intend to make any further amendments to the research as submitted and approved to date. This includes recruitment methodology; all changes must receive ethical approval prior to implementation. Please see https://ris.leeds.ac.uk/research-ethics-and-integrity/applying-for-an-amendment/ or contact the Research Ethics & Governance Administrator for further information fmhuniethics@leeds.ac.uk if required.

Ethics approval does not infer you have the right of access to any member of staff or student or documents and the premises of the University of Leeds. Nor does it imply any right of access to the premises of any other organisation, including clinical areas. The committee takes no responsibility for you gaining access to staff, students and/or premises prior to, during or following your research activities.

Please note: You are expected to keep a record of all your approved documentation, as well as documents such as sample consent forms, risk assessments and other documents relating to the study. This should be kept in your study file, which should be readily available for audit purposes. You will be given a two week notice period if your project is to be audited.

It is our policy to remind everyone that it is your responsibility to comply with Health and Safety, Data Protection and any other legal and/or professional guidelines there may be.

I hope the study continues to go well.

Best wishes
Sou Chung
On behalf of Dr Naomi Quinton, CHAIR, SoMREC

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Sou Sit Chung, Research Ethics Administrator, The Secretariat, University of Leeds, LS2 9NL, s.chung@leeds.ac.uk
Please note my working hours are Monday to Friday 9am – 12.30pm
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Appendix 8. Stimulus questions for Interview 3 [Year 2]

INTERVIEW 3 Topics for Conversation [21-30 March 2022]

1. Further reflection of Transcript 2:
   a. Tell me more about your thoughts on the chosen aspect from the transcript from our 2nd chat.
   b. Similarly, reflect a little more on the part of your story which I have selected.
2. What has been particularly memorable for you during your transition through Year 2, think about highlights or maybe troublesome aspects, if there were any?
3. What opportunities, or points in this academic year, have given you cause to think about your self-efficacy beliefs, in respect of any newly learned competencies? This could be anything, not just technical competencies.
4. What do you feel about your professional identity formation since you began your medical degree at Leeds?
5. Thinking in terms of identity change, how would you rate yourself as a doctor on a scale of 1-10, where 10 is a doctor; compared with the rating you gave yourself in Year 1?
6. In terms of the deep reflections, you demonstrated during our two previous discussions, do you feel that you were able to reflect on your transitional journey as you were progressing through Year 2? In what ways?
7. What impact did it have on you, academically, socially, and emotionally?
8. On a scale of 1-10, how would you now rate transitional experience since you began your medical undergraduate degree, where 1 = 'bumpy' and 10 = 'smooth'?
9. Based on your own experience and reflections so far, if you were to advise new first year medical students arriving at Leeds, how they might develop a positive and effective transitional experience during their first two preclinical years, what three things would you suggest to them?

11. REFERENCES LIST

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