Learning in practice

“Not a university type”: focus group study of social class, ethnic, and sex differences in school pupils’ perceptions about medical school

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Abstract

Objective  To investigate what going to medical school means to academically able 14-16 year olds from different ethnic and socioeconomic backgrounds in order to understand the wide socioeconomic variation in applications to medical school.

Design  Focus group study.

Setting  Six London secondary schools.

Participants  68 academically able and scientifically oriented pupils aged 14-16 years from a wide range of social and ethnic backgrounds.

Main outcome measures  Pupils’ perceptions of medical school, motivation to apply, confidence in ability to stay the course, expectations of medicine as a career, and perceived sources of information and support.

Results  There were few differences by sex or ethnicity, but striking differences by socioeconomic status. Pupils from lower socioeconomic groups held stereotyped and superficial perceptions of doctors, saw medical school as culturally alien and geared towards “posh” students, and greatly underestimated their own chances of gaining a place and staying the course. They saw medicine as having extrinsic rewards (money) but requiring prohibitive personal sacrifices. Pupils from affluent backgrounds saw medicine as one of a menu of challenging career options with intrinsic rewards (fulfilment, achievement). All pupils had concerns about the costs of study, but only those from poor backgrounds saw costs as constraining their choices.

Conclusions  Underachievement by able pupils from poor backgrounds may be more to do with identity, motivation, and the cultural framing of career choices than with low levels of factual knowledge. Policies to widen participation in medical education must go beyond a knowledge deficit model and address the complex social and cultural environment within which individual life choices are embedded.

Introduction

The principle that medical school intake should reflect the ethnic and socioeconomic mix of the population has been endorsed by the UK Council on Heads of Medical Schools1 and underwritten by generous “Widening Participation” payments to universities.2 But recruiting applicants from non-traditional groups is proving difficult,3 and major disparities by socioeconomic status and some ethnic groups remain.4

Contemporary theories of recruitment and retention in higher education explain students’ choices (and failures) primarily in terms of personal identity, social capital, and the cultural “frames” in which potential options are considered (see discussion). As part of a needs assessment to inform enrichment initiatives at University College London, we sought to find out what going to medical school meant to academically able 14-16 year olds.

Participants and methods

We approached six schools, chosen to provide a wide mix of socioeconomic and ethnic backgrounds (table 1); all agreed to participate. Teachers were asked to identify Year 10 and 11 pupils (age 14-16 years) who were predicted to gain high GCSE grades in subjects relevant to medical school and who had shown interest in applying. (Details of the background of each school and the research process are given in Box A on bmj.com).

To begin the focus group, the lead researcher showed a silhouette of a face and told the group: “This is X, who is a 16 year old pupil applying to medical school this year. She/He is probably going to do well—what do you think she/he is like?” After a discussion of the qualities of this “successful” fictitious pupil, the group were shown another silhouette and told “Y is a pupil of the same age who is thinking of applying to medical school—but she/he has got some concerns. What do you think these might be? What do you think the barriers might be to her/him succeeding?” The sex and ethnicity of the fictitious pupils were varied in different groups. Further discussion prompts were intro-

Details of the schools involved in the study and quotes illustrating the main themes from the study appear on bmj.com.
duced to explore the pupils’ perceptions and aspirations about medical school.

All focus group discussions were transcribed and annotated with contemporaneous field notes. Data were analysed using the constant comparative method (see bmj.com) and a preliminary list of themes circulated to a contact at each school for respondent validation.

Results

Sixty eight pupils from diverse ethnic backgrounds took part (table 1). We found marked differences by socioeconomic status as assessed by occupation of head of household. The main themes are listed below, and illustrative quotes are given in box B on bmj.com.

Focus group dynamics

In both the inner city focus groups that included boys there was a cohort of vocal “lads” with strong peer group identity exhibited through accent, dress, and behavioural norms, whose interjections were directed at subverting the purpose of the focus group through humour and “bad boy” activities (see box B on bmj.com for examples). These boys were highly able (one disruptive pupil from school A, for example, had recently won a national scholarship to study A levels at a leading private school) but presented themselves as non-academic and not really a serious part of the research study. Careers teachers confirmed similar behaviour from these boys in class.

Reasons for wanting to do medicine

Pupils from higher socioeconomic groups viewed medicine as having high intrinsic rewards such as personal fulfilment and achievement, and as one option in a menu of other high status career paths. Many such pupils had done their own research and had a clear strategy for pursuing their goal. Pupils from lower socioeconomic groups, especially boys, talked more about the extrinsic (financial) rewards of medicine and about the “blood and guts” of the job. They had a stereotyped view of doctors, often derived from media images, and had not tried to flesh out the detail of particular options.

Perceptions and concerns about applying to medical school

Many pupils had hazy perceptions of the steps needed to become a doctor (“Do you need any sciences?”). All believed that entry is highly competitive and were anxious about making the grade. Inner city pupils rated their chance of an application being successful at around 1 in 10 (in reality it is around 2 in 3). Pupils from comprehensive schools felt that not having perfect grades would put them at a disadvantage compared with applicants from “better” schools.

Few pupils had made a firm commitment to medicine by Year 11 (15-16 years old), and resented cutting off alternative choices at a young age. Independent school pupils were more confident that they would achieve a place at medical school and were less prepared to “jump through hoops” to bolster their applications. Pupils from the schools in the two most deprived areas often had only a vague idea of the alternative options (“There’s always cars”) available to them if they failed to make the grade for medicine, and boys in particular did not plan to make strategic “insurance choices.”

Who gets in?

All the groups gave a similar picture of the person who finds it easy to gain a place and succeed at medical school. Typical descriptors were intelligent, hard-working, dedicated, tough, interested in people, caring, enthusiastic, ambitious, and able to cope with pressure. There was a strong perception among less affluent pupils that high social class and a privileged education would confer an advantage in the admissions process.

What is medical school like?

Almost all pupils were ignorant of what actually goes on at medical school and about medicine as a profession. Pupils from inner city schools had concrete concerns about the physical environment at university, especially food choices and type of “dormitories”; more affluent pupils did not raise these issues at all.

Table 1 Characteristics of the six schools that participated in the focus group study

<table>
<thead>
<tr>
<th>School code</th>
<th>Type</th>
<th>Jarman score of area*</th>
<th>School catchment population</th>
<th>Composition of focus group</th>
<th>Occupation of head of household</th>
<th>Ethnicity and religion†</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Community comprehensive</td>
<td>53.10</td>
<td>Mixed 22% black, 52% Asian, 19% white; non-sectarian</td>
<td>Mostly routine, semi-routine, or unemployed</td>
<td>Mostly routine, semi-routine, or unemployed; one lower professional</td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>Voluntary aided comprehensive</td>
<td>45.45</td>
<td>Mixed ethnicity; non-sectarian Mix</td>
<td>7 white, 1 black, 3 other</td>
<td>Mostly routine, semi-routine, or unemployed; one lower professional</td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>Community comprehensive</td>
<td>54.59</td>
<td>Girls 99% Asian Bangladesh, Muslim</td>
<td>8 Asian, 3 not disclosed</td>
<td>5 unemployed; 3 own account workers; 3 not disclosed</td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>Community comprehensive</td>
<td>13.56</td>
<td>Mixed ethnicity; non-sectarian Mixed</td>
<td>11 white, 2 black, 1 Asian, 2 other</td>
<td>Broad range from routine to professional</td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>Voluntary aided comprehensive</td>
<td>19.65</td>
<td>Girls 23% black, 68% white, 2% Asian; Catholic</td>
<td>4 black, 1 white, 1 other</td>
<td>Broad range from semi-routine to professional</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>Independent selective</td>
<td>–28.57</td>
<td>Boys mixed, with “high proportion of Asians”; non-sectarian</td>
<td>7 Asian, 4 white, 4 other</td>
<td>Professional and managerial</td>
<td></td>
</tr>
</tbody>
</table>

*The Jarman (underprivileged area) score is a commonly used ecological measure of socioeconomic deprivation. The mean for England is zero. Scores >30 are considered to indicate substantial deprivation.
†These details were supplied by the schools or obtained from their prospectuses; where no detailed breakdown is given this was because the school did not wish to disclose these data.
All pupils perceived medical training as a long, hard course with little time for socialising. But there were important differences in what this meant for them. Pupils from professional backgrounds saw intrinsic rewards in the coursework (“tiring but fun”). Those from the lower professional and intermediate backgrounds described a trade-off (sacrifice now for rewards later). But pupils from lower socioeconomic groups often saw no intrinsic reward from the academic work (“it’s cruel”) and struggled with the idea of deferred gratification.

A few inner city pupils had a perception of university as “changing your life,” but this change was seen in distant, global, and somewhat unreal terms. When asked for specific examples, these same pupils could only cite individuals who had dropped out of university.

The high cost of medical training was a concern for all pupils, but those from professional families did not see it as influencing their choices. Some inner city pupils were dimly aware of scholarship schemes for which they might be eligible. Pupils from schools D and E (mostly lower professional and intermediate backgrounds) were concerned that they would be ineligible for financial benefits and that on graduation they would face severe financial hardship compounded by long hours and work stress.

There was a big fear about failing and dropping out. Inner city pupils greatly overestimated the likelihood of failing the course (one group rated this at 74%), and as the quotes on bmj.com show, this fear was closely linked to anxieties about money.

Need for information and resources

Pupils wanted information about what doctors do, what goes on at medical school, and admissions requirements, especially from independent sources that would allow them to compare the strengths and limitations of different courses. University websites and prospectuses gave admissions information directed at pupils aged over 16 years, but this was not experienced as meaningful by the younger age groups in this study.

Parental support was often mentioned spontaneously. Boys were more likely to see parental support in financial terms, whereas girls saw it more terms of psychological and emotional support, and, for the Asian girls, the opportunity to live at home.

All groups felt that talking to real students and recent graduates would be the best way of finding out what medical school (and medicine) is really like. The crucial characteristic of a credible person to speak to was homophily with the pupils themselves. Girls in particular wanted subjective and motivational information from someone they identified with (and who could identify with them).

The pupils from inner city schools were cynical about glossy brochures and people from universities who came round to market their courses. All groups were keen on work experience in which they met real patients and gained a flavour of what medicine is really like. The most useful placements were felt to be shadowing junior doctors. Some told stories of friends who had been given “unsuitable” placements (that is, without direct patient contact) such as microbiology labs or administration.

**Discussion**

This in depth study of London school pupils aged 14-16 years reveals important differences by socioeconomic background in perceptions of, and aspirations to, medical school, which both outweighed and moderated the influence of sex and ethnicity. Working class boys (those who identified their head of household as in a routine or semi-routine job or unemployed) showed a common pattern of intense peer group bonding, anti-school values, low self confidence despite high academic ability, and cynicism towards enrichment initiatives—a combination that may account for the continuing poor recruitment of both white and black pupils from lower socioeconomic groups to UK medical schools.

Two main approaches have been used to study how pupils choose their post-16 options. Quantitative surveys, in which participants are asked to indicate which of a list of possible factors influenced a particular choice, can test hypotheses about macro-level links between attainment variables (such as A level points) and application success. In depth qualitative studies provide a rich picture of a smaller number of individual decisions and are the method of choice for exploring the reasons for particular choices in defined subgroups.

Paul Willis, who undertook a detailed ethnographic case study of a group of “lads” in their final year of a
northern secondary modern school in the 1970s, made the controversial suggestion that the link between traditional working class identity and academic failure was embodied and reproduced in the social relations of the school itself.14 The lads’ resistance to school authority and rejection of its values allowed them to build a strong counterculture of “mucking about” and resisting work—but this very counterculture inexorably destined and prepared them for working class identities and jobs. A more recent study in an ethnically mixed sample produced similar findings.15

The notion that, despite the rhetoric of meritocracy, working class pupils cannot be classified as active choosers in education has been developed further by Bordieu,9 who sees choice as part of the “normal” middle class life narrative, in which a spell at university is highly congruent with family and peer values, financial security can generally be assumed, individual identity is independent of a particular locality and peer group, and the only choice is between institutions and courses. Others, drawing on Bordieu, have described the working class decision to enter post-compulsory courses. Others, drawing on Bourdieu, have described the working class decision to enter post-compulsory courses.15

On the basis of their empirical findings, Ball et al produced a theoretical taxonomy of higher education choosers based on two “ideal types”: contingent and embedded.17 Their model (which we have adapted slightly in table 2) accounts for many of the class differences we observed in our study.

Implications for policy

The UK government’s latest policy documents on widening participation recognise that achieving diversity in higher education must go beyond the knowledge deficit model and address the root causes of low motivation and cultural disaffection in non-traditional students.18 We discuss possible practical implications of this on bmj.com.

We thank the focus group participants and wish them success in their future careers. We thank the schools, especially our key contacts, for their work in making this study possible. Marcia Rigby was project manager, and Nazia Ali kindly assisted with the fieldwork in school C. We thank Lewis Elton, Stephen Rowland, Jill Russell, Sean Hilton, and Jane Hemsley-Brown for helpful comments on earlier drafts of this manuscript. We also thank BMJ Publications for a generous donation of books on learning medicine for the schools’ libraries.

Contributors: See bmj.com

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