

“Why not you?”: Discourses of widening access on UK medical school websites

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Abstract

Context

In the UK, applications to medicine from those in lower socioeconomic groups remain low despite much investment of time, interest and resources in widening access (WA) to medicine. This suggests that medical schools' core messages about WA may be working to embed or further reinforce marginalization, rather than to combat this. Our objective was to investigate how the value of WA is communicated by UK medical schools through their websites, and how this may create expectations regarding who is 'suitable' for medicine.

Methods

We conducted a critical discourse analysis of UK medical school webpages relating to WA. Our conceptual framework was underpinned by a Foucauldian understanding of discourse. Analysis followed an adapted version of Hyatt's analytical framework. This involved contextualizing the data by identifying drivers, levers and warrants for WA, before undertaking a systematic investigation of linguistic features to reveal the discourses in use, and their assumptions.

Results

Discourses of 'social justice for the individual' justified WA as an initiative to support individuals with academic ability and commitment to medicine, but who were disadvantaged by their background in the application process. This meritocratic discourse communicated the benefits of WA as flowing one-way: with medical schools providing opportunities to applicants. Conversely, discourses justifying WA as an initiative to benefit patient care were marginalized and largely excluded. Alternative strengths typically attributed to students from lower socioeconomic groups were not mentioned, implying that these were not valued.

Conclusions

Current discourses of WA on UK medical school websites do not present non-traditional applicants as bringing gains to medicine through their diversity. This may work as a barrier to attracting larger numbers of diverse applicants. Medical schools should reflect upon their website discourses, critically evaluate current approaches to encouraging applications from those in lower socioeconomic groups, and consider avenues for positive change.

Introduction

Widening access (WA) to medicine is a global issue, with each country's historical and social issues determining the focus of the initiative(1–4). In the USA, WA work concentrates on the recruitment of students from minority ethnicity and racial groups(5,6), whereas medical schools in Canada and Australia also focus on attracting those from rural areas and Indigenous populations(7–11).

In the UK, the term 'widening access' is applied to a diverse group of students who are underrepresented in higher education generally, including those from lower socioeconomic backgrounds or ethnic minority groups, mature or disabled students and those leaving the statutory care system. In medicine, currently the main focus of WA is on recruiting a representative percentage of students from lower socioeconomic backgrounds(2,12,13). As a result, diversifying the socioeconomic and family backgrounds of applicants and students is the primary criteria for measuring progress in WA to medicine in the UK(13).

However, despite a significant investment of resources by UK medical schools in WA (for example contributing staff time to planning and running outreach activities)(12,14–17), the number of applications to medicine from those in lower socioeconomic groups remains small. Using the Index of Multiple Deprivation (IMD) as a measure of socioeconomic status, 5.1% of UK applicants come from the least affluent 10% of households, with that number being as low as 1.8% in some regions(13). If only small numbers of students from these backgrounds are applying for medicine, extensive efforts to increase the socioeconomic diversity of the medical school population through the medical selection process itself(18) will have only limited impact. It is essential to encourage applications to medicine from diverse populations so that greater numbers of students from underrepresented groups can be selected.

What are the barriers to applying to medicine for those from underrepresented or 'non-traditional' groups? In most countries, high academic achievement is the first hurdle in the medical admissions process: there is extensive data to show that those in higher socioeconomic groups outperform those in lower groups on school exit examinations(19,20). However, it is not all about prior attainment: cultural, financial, social and school factors may also deter well-qualified non-traditional students from applying for university generally, and medicine specifically(21–28). In the UK context, where the vast majority of entrants progress to medical school directly from high school education, able and suitable applicants from non-traditional groups may be deterred from a career in medicine by their teachers(29,30) and, despite much WA outreach, may still feel that medicine is not for someone from their background(31–34). These persistent cultural barriers suggest that medical schools' key messages about WA may be failing to alter attitudes or even further embedding marginalization.

On the other hand, why should people from lower socioeconomic and other under-represented groups be encouraged to apply for medicine? The literature identifies that selective institutions such as medical schools typically consider WA as an initiative to address social justice for individuals by offering opportunities for social mobility, within a well-established discourse of meritocracy(15,35–38). However, there is also emerging acknowledgement that increasing the diversity of the medical profession may benefit the medical school learning environment(39–42) and improve workforce efficiency, including the competence and distribution of staff(8,43–47).

Exactly how the social justice and workforce management motivations for WA are currently combined – if they are indeed combined – within the context of UK medical schools is unclear. Cleland et al.'s(48) study interviewing UK medical school admissions deans found various, and often conflicting, interpretations and translations of WA policy. Many schools found reconciling the political goals of WA with their own aims, interests and resources problematic, especially with regards to their firmly held belief in 'selecting for excellence' through academic meritocracy. However, little is known about the influence that these differing values and attitudes to WA may have on aiding WA or reproducing processes of exclusion.

A series of papers have explored this within the Canadian context. Razack and colleagues(49–51) questioned whether the discourses – the institutionalized 'ways of thinking' that *enable and constrain* the way people think, act and communicate about an issue(50,52) - used by Canadian medical schools may act as a barrier to greater inclusion of diversity within the profession(49–51). In an analysis of Canadian medical schools' websites, policy documents and interviews with admissions committee members, they found tensions between the understandings of 'excellence in scholarship' and 'excellence in social accountability' with regards to admissions. Overall, 'excellence in scholarship' was presented as holding significantly more value, with more influential and prestigious schools enacting this discourse most powerfully.

Given that in the UK applications to Medicine from those in lower socioeconomic groups remain stubbornly low, despite attempts from medical schools to widen access, it is important to examine the messages being sent to these groups about why they should apply. We know that there are currently two main drivers for WA in this context (for social mobility and to increase workforce diversity) and that they may be causing challenges and tension in UK schools(48). However, no previous studies have examined how discourses of WA are transmitted by UK medical schools to prospective students in lower socioeconomic groups and what effect these may have. Razack et al.'s work(49–51) exploring similar issues in Canada, suggests this is an important topic, which may indeed have implications for attracting diverse students to Medicine.

This paper cumulatively builds upon Razack's et al.'s work, but takes a distinct analytical and conceptual approach within a different context: Our context is that of the UK, where 90% of medical programmes are undergraduate, and where the focus of WA is very much on increasing the representation of those from lower socioeconomic groups within medicine. We focussed on the messages potential applicants may gather from medical school websites as over 90% of students use these to inform a decision about where to apply(53) and an institution's written texts often influence (or even prescribe) the spoken communication of those within that institution(54).

This work employs a critical discourse analysis approach positioned within a paradigm of criticalism(55). This approach acknowledges the ideological and political influences on individuals' and groups' experiences and knowledge of social reality, and aims to expose, examine and challenge these, especially if they may be creating or reproducing inequalities. A key aim is to encourage positive change(56).

The following research questions focussed the work: How is the value of WA to Medicine communicated by UK medical schools through their WA webpages? What expectations are set up by these discourses with regards to who is 'suitable' for medicine and encouraged to apply?

Methods

Conceptual Framework

Our understanding of discourse is theoretically situated within the work of Michel Foucault. From this perspective, discourses are the (often taken-for-granted) 'rules' that enable and constrain a group's ways of thinking, and thus their production of knowledge and meaning. Discourses also sanction what is considered valuable, legitimate or expected within the group(57–60).

Within institutions such as medical schools, discourses are bound closely to institutional practice, regulating, organising and sanctioning what can be said, in which situations and by whom. Discourses thus reinforce social structures within institutions whilst concurrently, adherence to these structures further reinforces the discourses that creates them(52).

Within one context multiple discourses may be in use, and will constantly compete for dominance, power and status(52,60). Dominant discourses are those which are afforded greatest presence or authority, and which legitimate the current power relations and social structures(59). Once dominant, discourses work to secure their power by naturalizing themselves until they are no longer questioned by users(57). Thus discourses can entrench their position "precisely because they are able to make invisible the fact that they are just one among many different discourses."(61)^[p92] Language and power are not static constructions however, and alternatives are always possible. Therefore, counter-discourses challenge the dominant discourse as power flows in new directions and social structures adapt to the changing discourses and pressures(57,62).

A Foucauldian approach to discourse analysis particularly aims to expose the discourses in use within a context, in order to bring them out of the realms of being 'taken for granted' and allow them to be explored(52,57). Foucault's work also considers the implications discourses may have on the way people may think or feel, and how they might act. These are understood through an examination of *subject positions* and *subjectivity*(59,63).

Discourses create 'locations' (positions) within their framework of 'rules', into which those using or hearing that discourse (subjects) may be placed, or may place others within. These subject positions can be likened to 'vantage points' as they provide assumptions about what can be seen, said and done from within that location. Although these positions do not go as far as to create roles or parts to be acted out, if they are taken up by people exposed to or using the discourse, they enable and constrain the opportunities of those people – validating some speech and action, and silencing others. In such a way, certain behaviour and actions are legitimized for certain people, depending on their subject position(59,63).

Moreover, if taken up, these subject positions may influence a person's subjective experience (subjectivity). As well as enabling and constraining certain actions, this influences their thoughts, feelings and experiences. This does not claim to directly link language to thought or mental state, but does allow researchers to speculate about what the implications of the discursive structures and subject positions may be for people's subjective experience(59).

Data collection

In 2014 UK medical schools were recommended to improve the information about WA on their websites(30). Their accessibility, wide usage and importance in applicant decision making (53) meant that webpages about WA were considered a 'critical case'(64) (an occurrence that has

strategic importance for a general problem) for our analysis, and a springboard for further exploration should the results prove useful.

With one exception, all UK medical schools are public institutions: they receive funding from the government and are subject to state control, including policy directives to widen access. The independent medical school is not subject to the same directives so was excluded from our study. Websites of public medical schools were reviewed and material selected for inclusion in the corpus (collection of texts) as per steps (i) and (ii) described below.

In total, 25 of the 34 schools provided material about WA activities (e.g. summer schools, outreach visits, mentoring) and/or WA entry routes (graduate entry, foundation years, extended programmes or non-science entry routes) available directly *on their own* websites. The remaining nine medical schools did not provide this material on their school's site, either not mentioning WA or linking to material on a wider university admissions department site or online prospectus. We considered each medical school to be responsible for the content published on its own website and that this content represented the views, advice and policy of that school. As a result, to specifically focus our study on medical schools' presentations of WA, we used only text from their own websites.

The corpus included webpages from 25 medical schools:

- from across the UK
- 13 from large urban areas, 12 situated in smaller cities;
- 16 schools from universities in the 'Russell Group' (a collection of research-intensive and highly ranked universities), nine from universities outside this group (often more recently established); and
- representing the full range of course entry points, including: the UK standard five-year programme; three+three pre-clinical and clinical programmes; graduate entry programmes; and those with the specific aim of widening access

The volume of information available from each webpage varied widely with the smallest entry containing 325 words and the largest 6,965. Downloadable files such as policy documents, online prospectuses, or activity brochures were not included (unless considered to be in lieu of webpages) as they were considered less relevant to analysis: this material was less likely to have been primarily written for a public audience (policy documents); to be written or compiled by departments outside the medical school (prospectuses); or not represent the immediate and primary messages communicated to readers through websites (the majority of website visitors may not initially download and read detailed information).

The final corpus consisted of 433,815 words, collected from April to July 2015.

Data Analysis

Our study took a critical discourse analysis approach, following five steps:

- (i) The familiarization phase involved wide reading of all UK medical school websites to inform the development of guidelines for assembling an appropriate and relevant corpus.
- (ii) Data was collected by copying text from UK medical schools' webpages about widening access, widening participation or outreach, as well as pages or sections concerning 'alternative entry' routes or programmes (for applicants with graduate or non-science

qualifications, or from WA backgrounds). These entry routes may focus on different aspects of WA, but all consider the impact of attracting those in lower socioeconomic groups(30).

We chose to concentrate our analytical focus on the language used, as familiarization with the data indicated this to be a fruitful and meaningful medium and linguistic analysis matched with the strengths of our research group. Therefore, within this study, 'text' refers only to written language.

(iii) To guide analysis, we followed the analytical framework for critical discourse analysis by Hyatt(65), adapted specifically for this study. First, we 'contextualized' the material, in order to situate the texts within their wider context (essential for an accurate analysis of meaning(66)), and to draw out specific aspects for concentrated analysis. These aspects were:

- drivers (aims of WA policy, initiatives and activities)
- levers (instruments of policy implementation)
- warrants (justifications for actions or decisions)

These aspects were identified through a line-by-line textual analysis of the material, and coded within NVivo to aid data management.

(iv) Having identified all references to WA (both explicit and implicit) within the drivers, levers and warrants, we focussed on examining the similarities and differences in the way WA (our discursive object) was constructed. This was done through a systematic investigation of the linguistic features present in each statement, such as evaluative language, tone, register and audience address. Paying particular attention to how the value of WA was expressed, we considered the function of constructing WA in this way – for example, where was responsibility attributed or emphasis placed? By grouping statements with similar constructions together and comparing these to the wider discourses of the area, we teased out the discourses present.

We then considered the subject positions and subjectivities made available by these discourses by examining the 'vantage points' they offered to subjects in the texts – for example, which behaviours were legitimized or silenced. Finally, we searched for evidence of subjects taking up these positions and analysed these instances to uncover how speakers communicated their experiences from within that position. Analysis was informed by an approach outlined by Willig(59) and progressed iteratively, with researchers referring repeatedly to the data, theory, and wider context and discourses of the area to develop interpretations.

KA undertook the primary analysis, with understandings developed and refined through critical discussion with JC, SN and TFP. The group met at regular intervals to discuss and rigorously challenge the emerging interpretations through critical questioning. Full texts were accessible throughout analysis and discussion so that the team could confirm interpretation with careful consideration to a statement's co-text and context.

(v) Finally, medical schools with different attributes were compared to reveal any differentiation across the sector (See Table 1).

Overall, this analytical approach intended to expose the discourses concerning the value of WA across a range of UK medical schools, for these to be examined, evaluated and their implications considered.

Ethical Considerations

The research team contributed diverse educational and professional backgrounds and varied areas of expertise, including psychology, medicine and linguistics. As a result, this study has been influenced and uniquely formed by a range of perspectives, interests and motivations. KA is a PhD researcher whose professional background is in working in WA at an operational level (running and designing outreach projects and activities), whilst JC and SN bring a strong engagement with WA at an academic level. As a practicing clinician, SN provided a perspective from 'within' the medical profession, whilst JC, TFP and KA considered the profession from different 'outsider' perspectives. This diversity of perspectives facilitated the critical questioning of interpretations and power dynamics, and greatly aided the interdisciplinary and critical nature of the paper.

Moreover, these critical discussions offered the opportunity for heightened reflexivity and to expose and challenge team members' assumptions and biases. Throughout the research process KA recorded notes detailing the reasoning behind the decisions made and shared these with the research team, thus leaving no opportunity for choices to remain 'assumed' or unscrutinised. Finally, in an attempt to make any philosophical or institutional bias clear to the reader, we make our positions known by detailing our theoretical and professional contexts above.

Within the results, analysis is illustrated with quotations cited from medical school websites. These are identified with a randomly assigned numbers and school 'attributes' instead of by name (see Table One), in an attempt to preserve the identity of the schools, as is the approach in other such papers(36,49,67). As the data used was made publically available by medical schools this approach does not ensure the anonymity of schools included, but rather encourages the reader to assess the findings for medical schools as a group rather than focus on individual institutions, as was the intention of the paper.

Permission to conduct the study was granted by the College of Life Sciences and Medicine Ethics Review Board at the University of Aberdeen.

Table One

| Table One: Attributes of medical schools – key for interpretation of results | | |
|--|-------------------------|--|
| Category | Grouping & Abbreviation | Definition |
| Mission Group Affiliation | Russell Group (RG) | The Russell Group universities are a group of 24 research intensive UK universities which are highly ranked in worldwide league tables. Medical schools at these universities tend to have been established longer than those not in this group. |
| | Non-Russell Group (NRG) | |
| Location | Small Urban (SU) | Medical Schools situated in areas/cities of less than 500,00 inhabitants (68) |
| | Large Urban (LU) | Medical Schools situated in areas/cities of more than 500,000 inhabitants (68) |
| Entry Routes offered | Undergraduate (UG) | Standard entry course offered |
| | Graduate (GEM) | Graduate entry course offered |
| | WA (WA) | Course offered to widen access to Medicine: for example a foundation year, extended programme or route for students lacking appropriate science qualifications |
| Medical School Number | Example: Uni18 | All medical schools were randomly assigned a number to allow audiences to compare individual schools whilst attempting to preserve the identities of the institutions included. |

Results

The primary textual analysis of drivers, levers and warrants revealed that all schools communicated either explicitly or by strong implication that the purpose of WA was to ‘diversify the workforce’ or ‘diversify the student body’ by recruiting more students from WA backgrounds, particularly those from lower socioeconomic backgrounds. This is not a surprising result. However, it reveals only *what* WA is (increasing numbers of students from underrepresented backgrounds into Medicine), rather than the reasons *why* medical schools undertake WA (its value):

Widening participation schemes are designed to increase the numbers of successful applications to medical school from students with educationally disadvantaged backgrounds. (NRG SU UG/WA Uni28)

It is the aim of the [medical school] to fully support the University of X’s initiative to widen participation and thereby create a more diverse student population. (RG SU UG Uni27)

Levers (instruments of policy implementation) were occasionally cited as a reason to undertake widening access, however, again these did not overtly communicate the value of WA:

The [WA initiative] specifically supports access to high demand professional subjects and the university works with XXX to support Scottish Executive objectives. (NRG SU UG Uni18)

As a result, although the eventual aim of WA and the external pressures to implement this were usually made clear, its value (why it was undertaken) was more elusive to identify.

Discourse of WA for social mobility through academic meritocracy

Across all medical schools, individual participants were positioned as central to WA. For example, drivers (aims) primarily focussed on identifying and providing opportunities to selected individuals to increase their likelihood of application and admittance to medical school:

On this page is a list of programmes and activities run by current medical students and the University targeted at prospective students from under-represented backgrounds. The aim is to encourage them in considering medicine as a career and helping them to apply to study medicine. (RG LU GEM/UG Uni6)

In this way, WA was communicated as opening up access to medicine to those for whom this would not have been an expected career choice. This conveys the value of WA as aiding social mobility (equality of opportunity for individuals with regards to occupation or income, thus preventing the automatic transmission of disadvantage from one generation to the next(2)).

Warrants for this discourse centred on the concept of 'fairness' and social justice and was a consistent focus throughout many texts. Here WA was constructed as part of an admissions process that implied fairness for all applicants through selection based on meritocracy (selecting on the basis of merit rather than gender, race or class)(21):

[We are] committed to identifying the best possible applicants regardless of their personal circumstances or background. (RG LU UG Uni14)

Desirable forms of 'merit' were primarily communicated as academic achievement and/or academic ability, a commitment to study medicine and/or the potential to practice medicine. Anyone with sufficient merit was encouraged to apply:

WHO CAN STUDY MEDICINE...?

Why not you? Our tutors are looking for academically gifted students who are committed to a career in Medicine. Your school and general background are of no importance: if you hold, or are on predicted to achieve [grades], there is every reason to apply. (RG SU GEM/UG Uni32)

UK medical schools varied with regards to how they communicated the value of WA within this system of academic meritocracy. At one end of the spectrum, schools claimed that the use of WA did not diminish the key objectives of the system:

The central principles in selection remain that:

- selection decisions will continue to be based on the assessment of academic potential and aptitude for the respective professions
- by the declaration of transparent criteria, both academic and non-academic, false hope will not be offered to those considering application (RG SU UG Uni27)

For others, it was implied that WA was a means through which to encourage more students to apply, and thus allow medical schools to select the 'best' students from a wider selection:

We don't want to miss out on any talent, so if students have the ability, we want them to apply. (NRG LU GEM/UG Uni9)

Finally, some schools indicated that WA was a valuable tool in improving the fairness of the meritocratic selection process. Here, WA was shown to compensate for the lack of opportunities available to more privileged students. Warrants supported this on the grounds of fairness to talented individuals who would otherwise be at a disadvantage because of circumstances out with their control:

To prioritise interviews and adjust grades in order to provide a level playing field when competing against applicants from selective and fee paying schools. (NRG SU UG/WA Uni28)

[The project] recognises the disadvantage young people from non-selective state schools may face when applying to medical school. They may have the aspiration, desire and ability to study medicine but not receive the necessary support and guidance when making their applications. [The project] aims to rectify this. (RG LU UG Uni10)

Although aspects of this discourse varied across medical schools, it was united under the common value of WA as a tool within the selection system of academic-based meritocracy. Here, the driver to create social mobility for selected applicants was consistently communicated as ‘a given’ across the range of medical schools. Although the term ‘social justice’ was never explicitly mentioned in the corpus, this implicitly warranted the drivers’ aims through appeals to fairness.

Discourse of WA for workforce improvement through diversity

It was very rare to find statements that challenged this dominant discourse of WA for social mobility. However, within the webpages of two universities in our corpus a contrasting discourse was briefly presented.

In this alternative discourse, instead of the value of WA being focussed on creating opportunity for talented individuals, its value was communicated as meeting the needs of the wider workforce and patient care through the use of warrants (emphasis added by authors):

Greater diversity within the medical profession is a goal that benefits us all. [The] outreach programme at X seeks out young, talented people who have the potential to become doctors but who may not have considered it as a possibility...

[the project] aims to identify young people with the potential to become **tomorrow’s doctors** and who can contribute towards increased diversity within the medical profession, thus allowing medicine to better reflect the patient population.

(NRG SU UG Uni1)

Widening participation.

According to the British Medical Association, people from lower socioeconomic backgrounds use healthcare twice as frequently as the average – but only one in five UK doctors comes from these groups.

At XXX we offer a range of Widening Participation activities for schools and colleges to help raise aspirations, support young people’s choices and encourage progression into medicine and other medical careers. (NRG SU UG Uni15)

Rather than foregrounding benefit to the individual through the provision of social mobility, these statements communicate the value of WA to be primarily of benefit to society through the creation of a diverse workforce. Warrants claim that those in lower socioeconomic groups, and indeed the whole population, benefit from greater diversity and more balanced representation in the workforce.

The value of WA is also warranted through reference to the beliefs of other powerful institutions: including references to “tomorrow’s doctors” and “According to the British Medical Association...” The referral to the authority of other institutions’ directives may help to strengthen their statements, or may intend to divert any potential opposition to the statements away to other institutions.

Within the discourse of WA for social justice, the values of academic meritocracy were strongly embedded. However, the values attributed to this discourse (of benefit to society through a more diverse workforce) appeared to be missing in these texts. No webpages in our corpus mentioned traits often specifically attributed to non-traditional students from lower socioeconomic backgrounds: for example, a better understanding of diverse populations(39–41), a desire to work with underprivileged communities(44,46,47), multilingualism(69) or resilience in overcoming barriers(70). Thus no expectation was created that they were valued.

The very limited usage of the discourse for workforce efficiency and the exclusion of its associated values mean that this discourse is significantly marginalised in comparison to the dominant discourse of WA for the social mobility of individuals.

Relationships between medical schools and potential WA applicants

Within the dominant discourse of WA for social mobility, WA was shown to provide opportunities to students who would have traditionally not have considered medicine, and to provide compensatory activities to assist these students in becoming more competitive within the selection process. An analysis of the interaction between medical schools and participants within this discourse revealed that in the vast majority of instances the medical school discursively positioned themselves as the provider/facilitator of WA, and positioned the participants of their WA activities as recipients/beneficiaries.

For example, medical schools are shown to provide the benefits of WA to students, ‘allowing’, ‘helping’, ‘encouraging’ and ‘supporting’ them, whilst participants and teachers were presented as the group predominantly benefiting from WA:

Widening participation activity at XXX provides advice, information and guidance to allow students to make informed decisions concerning their future; thus providing them with the confidence to submit strong applications to study medicine. (NRG SU UG Uni18)

WIDENING ACCESS

Do you have challenges and barriers that are inhibiting your potential admission to medical or dental school? We’re here to help you overcome them. (NRG SU UG Uni12)

In a Foucauldian sense, this discourse creates and legitimizes a subject position for medical schools in which they are responsible for ‘providing’ WA through support and information. WA participants are seen to require and receive medical schools’ actions, legitimizing their position of disadvantage and deficit.

If taken up, these subject positions may also have implications for people’s experience, thoughts and actions (subjectivity). Through the publication of testimonials we can see some examples of school teachers, potential applicants and current medical students who had been part of WA activities taking up or acting from within this subject position, as their value-laden language expressed gratitude and debt for the provision of opportunity:

[Some of our pupils] were lucky enough to benefit from a presentation by [3 medical students]... I wanted you to be aware of how much we valued their time, energy and their encouragement of our students. (RG LU UG Uni10)

It has been a fantastic week and I’m so grateful that I was given a chance to experience this. (RG SU GEM/UG Uni32)

As current students at XXX, we continue to feel indebted to the hard work and the dedication of those who guided us to this destination.... We hope that more students are given the privilege to partake in such an opportunity. (RG LU UG Uni10)

The marginalized counter-discourse (WA for improved workforce and service provision) suggests a different model. Here, a diverse range of doctors can provide benefits to society through their difference, and thus WA participants may be positioned as contributors to improvements in the profession. However, no examples of the subjects positioned in this way were given, and no testimonials supported this discourse.

Discussion

This study examined how the value of WA is communicated by UK medical schools via the discourses on their WA webpages. We identified the dominance of an approach that emphasises the value of WA for an individual's social justice and mobility, which is perhaps not unexpected given the prominence of individualism within the UK's current neoliberal approach to higher education(15,71,72). However, it is perhaps surprising how strongly this discourse overpowers the counter discourse of the value of WA for the improvement of service provision and patient care, especially given the increasing presence of this argument internationally(8,39–47).

Institutional discourses reinforce institutional values and structures, and vice versa(52). The deep entrenchment and dominance of the discourse of WA for social mobility suggests that it retains significant power and legitimacy, with its associated values presented as 'taken-for-granted'. The Foucauldian approach of this study allowed this discourse (and opposing discourses) to be exposed, examined and evaluated for their implications(57).

Discourses shape and legitimize what is considered valuable and expected within a group, be this medical schools or WA participants. Expectations set up by the dominant discourse communicated that, to be suitable for medicine, WA students should display the qualities traditionally valued within a medical applicant (for example, highly academically achieving). On the other hand, alternative qualities often attributed to students from lower socioeconomic backgrounds (such as an understanding of underserved populations(39–41)) are excluded from webpages and thus are not communicated as valuable.

A Foucauldian approach also highlights the implications discourses can have for the way people think, feel and act. Positioning WA participants as the sole beneficiaries of WA reinforces that they are at a disadvantage within a system that foregrounds academic achievement and traditional values. Both applicants and medical students from non-traditional backgrounds are acutely aware of their difference to the majority of those around them, and continue to feel that they may lack the desirable attributes expected(15,50,73). As a result, highlighting their lack of competitive attributes and need for compensatory measures may not work to reassure potential applicants from lower socioeconomic groups or their advisers of their suitability for the degree or encourage an application(27,31,32,74,75).

Concurring with Cleland et al.'s study of UK medical school admissions deans' approaches to WA(48), our results show that academic meritocracy remains a tightly-held belief within UK

medical schools. This study reveals how justifications of WA for social mobility are also intertwined with promoting and preserving the dominance of academic merit within selection, with the approach and extent to which this is done varying across schools. Some of the tensions revealed in Cleland et al.'s study were also evidenced here, with two competing and unreconciled discourses found.

Razack et al.'s work in Canada led them to conclude that the dominance of discourses of academic excellence may act as a barrier to greater inclusion within the profession(49–51). We agree that the strong focus on academic merit in the UK texts may discourage diversity - potentially exacerbating the underlying concerns of potential applicants from lower socioeconomic backgrounds and further highlighting their disadvantage in a selection procedure focussed on academic credentials.

Yet, context is essential for the production and shaping of discourse(66) and this study reveals a significant difference between the discourses of social justice used by the medical schools in Canada and the UK: Razack et al.'s study of Canadian medical school websites found that when equity in social accountability ("discourses in which there is a social justice concern") was presented, this was as "justice in healthcare delivery rather than as a tool of social advancement of the individual being educated"(49) ^[p1328]. This is a strong contrast to the findings of our study and emphasises the context-specificity of discourses. It would be of interest to know more about the dominant discourses of WA in other countries and settings.

By exposing and examining discourses, medical schools can analyse their texts and consider whether these are actually reproducing a process of exclusion. This may encourage an appreciation of how texts about underrepresented groups might actually be serving to continue to unintentionally exclude these groups from medical education, and hence medicine, and aid reflection on how to change practice and thought with respect to greater inclusiveness. Moreover, on the other side of the fence, little is known about how those with marginalised viewpoints - the potential applicants from lower socioeconomic groups, their parents and teachers - understand the value of WA, nor how medical school discourse may influence their decision to apply to medicine. Further research is needed to investigate the effects current discourses of WA have on attracting a truly diverse cohort of students to medicine.

Although this study draws divisions between 'ways-of-thinking' about the value of WA, this is primarily intended to aid clarity and understanding within an area of contradictions and confused understandings(48). These constructed divisions do not mean to imply that these approaches, or elements of them, cannot be combined or reconciled. For example, if medicine wishes to truly diversify its intake, there have been increasing calls to consider a wider re-definition of merit to also include values seen as advantageous to the competency and distribution of the workforce(1,8,9,26,50,76). This would enable the profession to maintain a meritocratic system, but explicitly recognise and acknowledge the value of diversity. This would be one way of encouraging a truly wider group of applicants, rather than merely attracting the traditional (academically excellent and already committed to medicine) students from within non-traditional or underrepresented groups.

Examining WA webpages allowed a large number of diverse schools from across the UK to be compared through one important genre, in terms of the utility of webpages to applicants and the relationship between written and spoken text within institutions(53,54). However, as a minority of UK medical schools did not provide WA material on their websites, our study was limited to

including material from only 25 of 34 possible schools. The specialized nature of the purpose-built corpus afforded researchers advantages when addressing the questions for which it was designed, however, future studies may fruitfully examine additional genres of material (for example prospectuses, field notes from open days, or interviews with admissions staff) to expand such an investigation.

This study examined language use only, with the aim of producing high quality focussed enquiry. However, excluding aspects such as images and typography decontextualized the text and limited the perspectives available to our analysis. Further studies in this area could consider multi-modal analysis to access these additional perspectives. In addition, our paper only considered how these pages communicated the value of WA to potential applicants, whereas attention could be directed to examining a range of functions of these pages – from positioning the school within a competitive market, to how they address stakeholders or regulatory bodies.

Finally, as discussed, the term ‘WA’ encompasses many different groups of people depending on the context – from those in minority ethnic groups, to Indigenous populations, to rural or disabled applicants. Further studies could consider the implications of discourses on attracting students from these additional WA groups to medicine.

In conclusion, discourses on UK medical school websites overwhelmingly communicate that WA is practiced in the name of justice to ‘traditionally talented’ individuals who have been disadvantaged because of circumstances beyond their control. If UK medical schools believe that students from under-represented groups have additional strengths to offer to the medical school or workforce through their diversity, this is not being communicated effectively. Current discourses, and the expectations that they create and perpetuate, may not be acting to alleviate the worries of many potential applicants from WA backgrounds, nor to reassure them of their aptitude for medicine or encourage them to apply. If medical schools wish to attract larger numbers of able and *truly* diverse applicants to medicine from lower socioeconomic backgrounds, it is vital that they critically evaluate their current approaches to attracting such applicants and consider avenues for positive change.

Contributors

KA and JC had the original idea for the study and developed the study design in collaboration with SN and TFP. KA collected the data and undertook the analysis, with understandings developed and refined through critical discussion with JC, SN and TFP. KA drafted the paper, with JC making significant contributions to resulting redrafts, and SN and TFP contributing to further revisions. All authors approved the final paper before submission.

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