Medical Trailblazers – working-class students' experiences of becoming a doctor.

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

Dedications

For my mum, Mrs. Margaret Webb.
You were stronger than you ever knew. Your sense of humour, your kindness, and your

unwavering belief in doing what is right have shaped the person I strive to be. Your legacy is my compass, and it has given me the strength to choose goodness, even when things are difficult. Thank you for everything.

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Thank you for being strong, kind, and extraordinary young women. Watching you grow has been the most incredible honour of my life. You inspire me every day with your courage, your compassion, and your authenticity. Always stay true to who you are, because who you are is amazing!

To the invisible working-class women.
Your voice is your greatest power. Use it boldly and unapologetically. The world needs your truth, your strength, your story. You are so much more than what others choose to see. Show them who you truly are, and all that you bring to the world.

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Prologue: A Matter of Life and Death

This thesis has been both a challenge and a labour of love. As a working-class PhD student, mother, daughter, wife, and lecturer, I have lived and worked on the margins of a class-stratified society. My motivation for this research did not emerge overnight. It grew over a lifetime of marginalisation, resilience, and a deep commitment to advocating for working-class women and children like me who have faced an uphill struggle to access a life worth living.

My mum used to say, ‘We are all born with fire in our belly; over time, life puts out the fire, and we accept our lot'. Her words have stayed with me, especially since she died in 2012, a loss that profoundly shaped my academic and personal journey. In July 2011, after a blue-light hospital trip, resuscitation, and a week on a ward, my mum was diagnosed with Chronic Obstructive Pulmonary Disorder. Scarring on her lungs had been present since childhood pneumonia, and her years working in the wool mills had further irritated her chest. A 20-a-day smoking habit had compounded her vulnerability. During check-ups, she was advised to keep an emergency pack of steroids and antibiotics on hand in case of infection. The hospital doctor assured us that her GP would prescribe them.

The GP, however, refused. He insisted he would not prescribe antibiotics without a clinical presentation of infection. My mum, who had grown up working-class in a northern town, accepted this dismissal as normal. As Marmot (2010) shows, health disparities across the UK are deeply tied to geography and class. Despite our efforts to advocate for her, my mum entered the 2011 Christmas period without the protection she needed.

On January 1st, she developed what we thought was a cold. By the evening of January 2nd, she was breathless. An ambulance was called. At 10 pm, I was in the ambulance with her. She asked, ‘Clare, am I going to die?’ I reassured her. She said, ‘You know I love you, don’t you?’ I said, ‘I love you too’. Moments later, her lips darkened, and she lost consciousness. While the paramedic prepared equipment, I performed CPR. The machinery eventually restored her pulse, but she never regained consciousness. For over two hours, doctors tried to deliver oxygen to her lungs manually. Her stomach swelled. I spent much of that time trying to preserve her dignity, covering her body. At 00:46 on January 3rd, 2012, at the age of 64, my mum died from preventable pneumonia.

Afterwards, the paramedic apologised. He had not anticipated a full collapse. I thanked him for his kindness. That moment of gratitude, like so many others in our lives, reflected the internalised social stratification of class, the belief that we should be grateful for any human kindness from those in power. We did not complain. In my mum’s words, ‘we accepted our lot’. The doctors lost a patient. We lost our matriarch, our guidance, and our unconditional love.

Like many working-class people, my mum had little influence over the treatment she received and few resources to challenge medical authority. We were used to things being done to us. She had grown up as one of six siblings, and at 11, when her father left, she stayed home from school to care for her younger siblings. She could barely read or write, but she used humour and wisdom to tell us stories. Her dream was to own a cleaning company. As a family, we lacked the social, cultural, and economic capital to make that happen.

Three years after her death, I began a foundation year in Social Science at the University of Leeds. I had resat my GCSEs and passed my driving test. I wanted to change the course for my daughters. But the feeling of being ‘less than’ did not vanish when I entered middle-class institutions. I had to disregard my parents' advice and step into spaces where I often felt unwelcome, as the rest of my family had internalised difference and opted out of crossing into elite spaces. Over the past nine years of studying sociology, my mother’s words have echoed in my mind. I now understand that she was describing a life full of challenges, one in which she faced judgement with dignity and resilience and recognised the lack of choice afforded to working-class women.

This thesis is grounded in what Collins (2001) describes as the addition of wisdom to knowledge. My lived experience adds dimensions to my thinking beyond traditional academic research. I recognise the barriers that working-class people face when entering institutions that have historically marginalised them. Society often places them at the bottom based on their birthplace, parental education, and occupation, rather than recognising them as equals with aspirations, resourcefulness, and a wealth of skills to contribute positively to all professional roles.

As Bourdieu (1992) suggests, those whose habitus aligns with institutional norms move through systems like ‘a fish in water’. For the rest of us, the journey is more turbulent. However, institutions and educators can learn. The question is whether working-class students and colleagues can successfully challenge structural inequalities to secure equal opportunities and a seat at the table. In my mum’s case, someone who treated her as an equal and listened to her might have extended her life.

In my role as a lecturer at the University of Leeds, I often hear from my students that having a tutor who understands their background helps them feel seen and supported. Replicating these feelings for medical students has the potential to transform their lives and improve the health outcomes of those they treat (Rose, 1997). Working-class representation matters not as a token gesture but as an essential step towards equity and justice in education and healthcare.

This prologue is both a personal reflection and a methodological statement. It acknowledges that research is never fully neutral and that the researcher’s biography inevitably shapes the research process. By situating myself within the study, I aim to maintain reflexivity and transparency, recognising that both academic frameworks and lived experience shape my interpretations. This thesis calls for listening to the stories, struggles, and strengths of those who have often been silenced, and for recognising that knowledge is produced not only through theory but also through experience. In doing so, I position this work within a tradition of critical, engaged scholarship that values emotional insight, challenges structural inequality, and seeks to amplify voices long marginalised in academic and professional spaces.

Abstract

This thesis critically examines the underrepresentation of working-class individuals in the UK medical profession, arguing that this disparity both reflects and perpetuates broader structural inequalities across higher education, healthcare, and society. Despite decades of widening participation initiatives, medicine remains predominantly staffed by those from managerial and professional backgrounds, and working-class voices are largely absent from the institutions that shape and deliver care (Friedman and Laurison, 2020; Social Mobility Commission, 2016).

Drawing on qualitative data from surveys and interviews with working-class medical students, I examine how class identity intersects with institutional culture, educational policy, and professional expectations. Using a sociological framework grounded in Bourdieu's (1986) concepts of habitus, capital, and symbolic violence, alongside Yosso's (2005) theory of community cultural wealth, I analyse how students navigate elite spaces that often misrecognise their cultural and emotional resources and contributions to equitable care.

My findings reveal that working-class students face not only economic barriers but also cultural exclusion, which demands emotional labour and fosters persistent misrecognition. While many demonstrate remarkable adaptability and commitment, their success often carries a personal cost, including pressure to relinquish valued aspects of their working-class identity to conform to middle-class institutional norms.

Crucially, I argue that working-class students bring unique value to medicine. Their lived experiences foster empathy, cultural humility, and relational understandings of care that are often absent from traditional medical training (Skeggs and Loveday, 2012; Reay, 2017). These students possess navigational, resistant, and familial capital, which enrich patient care and challenge deficit-based assumptions in clinical settings (Yosso, 2005; Crew, 2025).

I call for a reimagining of medical education and recruitment practices that move beyond symbolic inclusion to structurally recognise the legitimacy, insights, and contributions of working-class individuals. By centring their lived experiences, I aim to contribute to a more equitable, representative, and socially just medical profession.

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Introduction

While the prologue offers a personal account of the lived effects of class-based inequality, this introduction situates those experiences within a broader sociological and educational framework. This study outlines the conceptual, empirical, and policy approaches that inform this research, drawing on critical sociological theory to examine how class operates within elite professional training. By shifting from the personal to the structural, this chapter establishes the rationale for the research, defines its scope, and positions the study within ongoing debates about widening participation, social mobility, and institutional culture in medical education. It also presents the key research questions and theoretical perspectives

that underpin the analysis, setting the scene for a more in-depth exploration of how working-class students experience, navigate, and challenge exclusion throughout their journey into the medical profession. Understanding class as a lived and affective condition enables us to interrogate not only who gains access to elite spaces such as medicine but also how inclusion is experienced once inside.

To understand the experiences of working-class medical students, it is unhelpful to attempt to define social class based on household income, parental occupation, or cultural preferences such as sports or music (Savage et al., 2015). These indicators, while useful in many contexts, risk oversimplifying the complex and dynamic nature of class identity. Instead, this thesis engages with class as a lived, structural, and affective condition, as Tyler describes it, 'the problem that class describes' (2015:494). This framing enables a more nuanced examination of how class shapes educational experiences, institutional belonging, and the formation of professional identity, particularly within elite fields such as medicine.

While access initiatives focus on economic disadvantage, they often overlook the deeper psychological and cultural consequences of social mobility, particularly its impact on identity and belonging. This research begins with the premise that access to elite educational spaces does not equate to inclusion. The illusion of a 'classless environment' (Hanley, 2017:12) persists in higher education, particularly in competitive disciplines such as medicine, where widening participation initiatives are often treated as sufficient. Yet these efforts frequently focus solely on economic disadvantage, overlooking the cultural, emotional, and institutional barriers that continue to shape students' experiences within the academy (Reay, 2017; Bathmaker et al., 2018; O'Sullivan, 2023). As a result, working-class students may gain entry but remain marginalised within the dominant institutional habitus (Reay et al., 2001; Atkinson, 2011). This thesis argues that without addressing the deeper cultural and structural inequalities embedded in medical education, efforts to widen participation risk becoming a symbolic gesture rather than a transformative practice. To understand how these disparities persist despite policy efforts, it is necessary to examine the institutional mechanisms that shape access and belonging, particularly through Bourdieu's lens of capital and habitus (Bourdieu, 1986; Reay, 2015; Bathmaker, 2018).

While sociological research has extensively examined the frequency of social mobility, there remains a limited understanding of its impact on identity, sense of self, and belonging (Paulson, 2018; Lehmann, 2014). This thesis addresses that gap by focusing on working-class students entering medicine, a profession historically aligned with middle-class norms and values (Beagan, 2005; Bourdieu, 1986). According to Friedman and Laurison (2020), over 70% of UK doctors come from managerial and professional backgrounds. More recently, Latham et al. (2025) found that only 5% of doctors come from families with traditional working-class occupations. Although this represents a modest improvement on the 4% reported by the Social Mobility Commission in 2016, it remains starkly disproportionate, given that nearly 40% of the UK population identifies as working class (Social Mobility Commission, 2016; 2024). These figures underscore the medical profession's enduring exclusivity and the need to examine the mechanisms by which class-based exclusion is perpetuated. Beyond institutional barriers, working-class students also bring cultural values that shape how they navigate elite spaces, values often overlooked in dominant discourses.

Defining Social Class: Policy, Theory, and Lived Experience

Social class is a contested and politically charged concept, and research on classed experiences must therefore make explicit how class is defined and operationalised. In UK policy contexts, class is often measured using structural indicators such as parental occupation, income, educational attainment, and neighbourhood deprivation. Bodies such as the National Audit Office and the Social Mobility Commission typically rely on occupational classifications, including the National Statistics Socio-economic Classification (NS-SEC), alongside proxy measures such as eligibility for free school meals, school type, and postcode-based indices of deprivation. These measures are valuable for identifying inequalities at the population level and for monitoring widening participation initiatives; however, they tend to treat class as a static attribute rather than a lived social relation (Reay, 2017; Friedman and Laurison, 2020).

Sociological approaches offer a more relational understanding of class. Bourdieu's theory of capital and habitus conceptualises class as a dynamic interplay among material resources, social positioning, and embodied dispositions shaped by socialisation and institutional participation (Bourdieu, 1986; Bourdieu, 1990). From this perspective, inequality is reproduced not only through economic disadvantage but also through symbolic processes of misrecognition and symbolic violence, in which dominant middle-class norms are naturalised and presented as neutral or universal (Bourdieu, 1994). Feminist and critical class scholars have extended this analysis by foregrounding the roles of moral value, respectability, and emotional labour in reproducing classed hierarchies, particularly in elite institutional spaces such as universities and professional training environments (Skeggs, 1997; Loveday, 2015; Reay, 2015).

Within this thesis, social class is therefore understood as relational, experiential, and embodied, rather than solely as an economic or occupational category. Structural indicators were used pragmatically to support recruitment and to situate participants within widening participation frameworks; however, they were not treated as sufficient to explain how class was experienced or negotiated. This approach aligns with scholarship that conceptualises class as something felt and enacted through everyday encounters with institutions, authority, and legitimacy, particularly in contexts where middle-class norms dominate (Tyler, 2015; Hanley, 2017; O'Sullivan, 2023).

These multiple understandings of class are not treated as competing definitions but as analytically complementary. Importantly, participants in this study did not define class exclusively in economic terms. Instead, class was articulated through narratives of insecurity, belonging, and difference, often in relation to peers more familiar with higher education and the medical profession. Participants described class through accounts of family histories, reliance on state education, geographical location, and early encounters with institutions that positioned them as outsiders. Class was frequently understood relationally, as something made visible through comparison with others and through moments of misrecognition in university and clinical settings. These participant-defined understandings of class are evident throughout the analysis chapters, where accounts of accent modification, financial precarity, commuting patterns, and differing relationships to home and family illustrate how class was lived rather than merely identified. By centring these narratives, this thesis treats class not as a background variable but as a core analytical lens through which inequality, identity, and professional formation are examined.

To understand this disparity, it is essential to move beyond economic capital alone. While financial hardship is a significant barrier, it is the interplay of economic, cultural, and social capital, and their recognition or misrecognition within institutional settings, that shapes access, belonging, and success (Bourdieu, 1986; Reay, 2019; Skeggs and Loveday, 2012). Medical education continues to privilege those whose habitus aligns with dominant institutional norms (Balmer et al., 2017; Crew, 2025). These norms are often unspoken yet deeply embedded in the expectations, language, and behaviours that define professional legitimacy. This thesis, therefore, explores how working-class students navigate the medical field, not only in terms of entry but also in sustaining their identities, values, and aspirations within a profession that often fails to reflect their realities.

A central focus of this research is the cultural and emotional significance of hard work and pride in working-class communities. These values are well documented in sociological literature (Skeggs, 1997; Reay, 2017; Hanley, 2019) yet remain underexplored in relation to their mobilisation within elite professions. While hard work is often celebrated in policy discourse, it is rarely examined as a form of cultural capital that carries emotional and symbolic weight (Gillies, 2005; Loveday, 2015). This thesis investigates how working-class students draw on these values to navigate exclusionary environments, and how pride may serve as both a protective resource and a source of emotional labour (Wiegmann, 2017; Rickett and Morris, 2020). These values are not only personal but also professional assets, particularly in medicine, where relational care and empathy are increasingly recognised as essential (BMJ, 2025).

Moreover, this research highlights the value that working-class students bring to the medical profession. Their lived experiences often foster empathy, cultural humility, and a relational understanding of care grounded in everyday realities (Greenhalgh et al., 2004; Yosso, 2005). These students frequently demonstrate resourcefulness, resilience, and a strong ethic of responsibility, qualities that enhance patient-centred care and challenge deficit-based assumptions in clinical settings (Balmer et al., 2017; Crew, 2025). Rather than viewing their backgrounds as obstacles to be overcome, this thesis positions working-class identity as a source of insight and strength within medical education and practice. As Krstic et al. (2021) argue, students from widening participation backgrounds often bring unique perspectives that enrich the learning environment and improve the profession's responsiveness to diverse patient populations. However, despite the potential of these contributions, institutional cultures often fail to recognise or reward the forms of capital that working-class students bring.

Consequently, despite these strengths, institutional culture still poses significant challenges. Research shows that institutional habitus—the ingrained norms, values, and expectations within educational environments—often reflects middle-class assumptions about behaviour, communication, and professionalism (Reay et al., 2001; Atkinson, 2011). These assumptions can marginalise students whose cultural capital does not align with dominant norms, reinforcing feelings of exclusion and imposter syndrome (Loveday, 2015; Skeggs and Loveday, 2012). In medical education, this misalignment is particularly pronounced, as students are expected to demonstrate confidence, competence, and cultural fluency in high-stakes settings that rarely recognise the diversity of their backgrounds (Michalec, 2011; Jenkins et al., 2021). The hidden curriculum, the unspoken rules and expectations that shape professional identity, often exacerbates these exclusions (Hafferty, 1988; Hopkins et al., 2016). This thesis, therefore, investigates how institutional cultures within UK medical

schools influence the experiences of working-class students and how these students navigate, resist, or adapt to the unspoken rules of elite professional training. These values are not only personal but also professional assets, particularly in medicine, where relational care and empathy are increasingly recognised as essential components of effective practice. However, for working-class students, the emotional toll of navigating elite educational spaces, where such values are often undervalued, can be profound, involving symbolic violence and emotional labour that undermine confidence and a sense of belonging (Reay, 2019; Rickett and Morris, 2020).

Thus, the psychosocial dimensions of pride and hard work warrant deeper exploration. Reay (2015) and Loveday (2015) demonstrate that emotions such as shame, pride, and anxiety are not merely personal experiences but are socially produced through interactions with institutions and peers. For working-class students in medicine, pride may buffer against imposter syndrome and symbolic violence; however, it can also mask the emotional toll of navigating unfamiliar and often hostile environments. Emotional labour, the effort required to manage feelings and present oneself in ways that conform to institutional expectations, is a recurring theme in the narratives of working-class students (Hochschild, 2003; Rickett and Morris, 2020). This thesis explores how students manage these emotional demands and how their experiences challenge dominant narratives of resilience and meritocracy.

This thesis makes a distinctive contribution to the sociology of medical education by applying and extending Bourdieu's theory of social reproduction through the lens of Yosso's (2005) Community Cultural Wealth framework. While Bourdieu's (1986) concepts of habitus, capital, and symbolic violence illuminate how medical education reproduces class-based inequality, this study challenges the deficit framing often associated with his work. By integrating the Community Cultural Wealth framework, the research foregrounds the cultural, emotional, and relational assets that working-class students bring to elite professional spaces. This dual framework enables a more nuanced analysis of how students both experience and resist exclusion, offering a class-conscious critique of widening participation policies and calling for institutional transformation that recognises diverse forms of capital and belonging.

To explore these issues, this thesis adopts a qualitative methodology grounded in reflexive thematic analysis (Braun and Clarke, 2006, 2019). Data were collected through an online qualitative survey and semi-structured interviews with working-class medical students across various stages of training. This approach was chosen to capture the depth and complexity of participants' lived experiences, allowing them to articulate their identities, challenges, and strategies in their own words (Bullock, 2016). The research is informed by a critical realist epistemology and underpinned by the researcher's own positionality as a working-class academic. This reflexive stance acknowledges that knowledge is co-constructed and shaped by biography, emotion, and context (Coyle, 2020; Rose, 1997). By centring participant narratives and embedding reflexivity throughout the research process, the study aims to produce insights that are both theoretically grounded and socially situated.

Guided by this qualitative methodological approach, the study addresses the central research question: How do working-class students experience, navigate, and make sense of medical education in the UK? It further explores how institutional cultures shape these experiences and how students draw upon cultural and emotional resources, such as resilience, familial support, and community values, to persist and succeed within elite academic and clinical environments. By foregrounding the voices of working-class medical

students, an underrepresented group in both medical education and sociological research, this thesis offers original insights into the emotional and structural dimensions of classed experience. It challenges dominant narratives of meritocracy and resilience, instead presenting a more critical, reflexive, and emotionally grounded account of how class identity intersects with professional formation in the medical field.

Overall, this thesis provides a critical and emotionally grounded examination of how working-class students experience, navigate, and reshape medical education in the UK. By centring their voices, it challenges dominant narratives of meritocracy and resilience, exposing the cultural, emotional, and institutional labour needed to belong in elite professional environments. The chapters that follow build on this foundation. Chapter 1 reviews the literature on social class, medical education, and widening participation, focusing on the theoretical frameworks informing this study. Chapter 2 details the methodological approach, including data collection, analysis, and ethical considerations. Chapters 3 and 4 present the findings, emphasising students' experiences of identity, belonging, and institutional culture. Chapter 5 discusses these findings in relation to the theoretical framework, highlighting their implications for policy and practice. The final chapter offers conclusions and recommendations for fostering a more inclusive, equitable, and socially responsive medical education system.

Theoretical Framework

Introduction

This chapter first outlines Bourdieu's theory of social reproduction, focusing on habitus, capital, and symbolic violence. It then introduces Yosso's Community Cultural Wealth model as a complementary framework that foregrounds the agency and cultural assets of working-class students. Finally, it synthesises both perspectives to propose a more inclusive lens for understanding classed experiences in medical education.

This theoretical framework draws on Bourdieu's sociological insights and an adapted version of Yosso's (2005) Community Cultural Wealth (CCW) model to explore how class inequality is reproduced and challenged within medical education. Bourdieu's concepts of habitus, capital, and symbolic violence offer a compelling lens for understanding how social structures influence individual dispositions, opportunities, and outcomes, particularly in elite institutional settings such as medicine (Bourdieu, 1986; Bourdieu and Passeron, 1990; Reay, 2015). His work reveals the often-invisible mechanisms through which privilege is sustained, and marginalisation becomes normalised, especially for students whose social and cultural backgrounds differ from dominant institutional norms (Balmer et al, 2017; Bathmaker, 2015).

While Bourdieu's theory helps explain how inequality is reproduced, it has been criticised for portraying working-class students in terms of what they lack and for its limited engagement with the agency and cultural resources of marginalised groups (Reay, 2004; Skeggs, 1997; Gillies, 2005). To address this, the framework incorporates an adapted version of Yosso's (2005) Community Cultural Wealth model. Developed initially within Critical Race Theory to challenge deficit narratives about racially minoritised students, CCW identifies six forms of capital, aspirational, familial, linguistic, social, navigational, and resistant, that students draw upon to navigate and challenge exclusionary educational systems (Yosso, 2005).

Although CCW was initially developed in the context of race, recent scholarship has demonstrated its relevance to class-based inequalities, particularly in elite educational settings (Jackson-Cole and Chadderton, 2025). In this study, Yosso's framework is reinterpreted to focus on class rather than race, drawing on recent UK-based scholarship that has extended CCW to include the experiences of working-class students in elite higher education (Jackson-Cole and Chadderton, 2025; Doyle, 2022; Sangha, 2022). This adaptation acknowledges that, although CCW was designed to highlight racialised experiences, its central insight, that marginalised students possess valuable yet often unrecognised forms of capital, can be effectively applied to class-based inequalities. In doing so, it aligns with critiques of meritocracy and the cultural devaluation of working-class identities in higher education (Gillies, 2005; Reay, 2017; Friedman and Laurison, 2020).

Building on this reinterpretation, the framework also incorporates emerging forms of capital that reflect the evolving nature of cultural wealth in marginalised communities. The adapted CCW framework further expands on emerging research recognising additional types of capital, such as 'perspective capital', a critical awareness of structural inequality developed through navigating marginalisation, which can be utilised to legitimise one's presence in elite academic environments (Jackson-Cole and Chadderton, 2025; Rollock, 2012; Collins, 1986). Although not included in Yosso's original model, this form of capital reflects the ongoing development of CCW and its flexibility across social contexts.

By integrating these insights, the framework moves beyond deficit-based narratives to highlight the strengths and strategies of working-class students. It challenges deficit-based assumptions and emphasises the strategic, emotional, and intellectual resources students bring to medical education. It also enables a more nuanced analysis of how these capitals interact with institutional habitus and symbolic violence, thereby shaping students' sense of belonging, identity, and professional development (Reay et al., 2001; Atkinson, 2011; Loveday, 2015).

Taken together, the insights of Bourdieu and Yosso provide a multidimensional theoretical foundation for this study, enabling a critical examination of both structural constraints and student agency. They encourage exploration of how institutional norms and expectations intersect with students' social identities, and how students resist, adapt to, or are reshaped by these structures. This framework supports a move away from deficit models and towards recognising working-class students' cultural wealth as a vital resource in medical education (Baxter et al., 2015; Boursicot and Roberts, 2009; Shields, 2023).

Bourdieu's Theory of Social Reproduction in Medical Education

In this thesis, misrecognition is understood as the process through which dominant institutional norms are perceived as neutral, legitimate, or deserved. Symbolic violence denotes the effects of this misrecognition on working-class students' identities, emotions, and practices, including the internalisation of shame, self-doubt, and pressure to conform (Bourdieu, 1994; Burawoy, 2019).

Bourdieu's sociological theory provides a foundational framework for understanding how social inequality is perpetuated through educational institutions. At the core of his framework are the interconnected concepts of habitus, capital, and symbolic violence, which together reveal the mechanisms by which privilege is upheld and marginalisation is normalised. These concepts are particularly useful for examining the experiences of working-class

students navigating elite environments such as medical schools, where institutional norms often mirror and reinforce middle-class values and expectations (Bourdieu, 1986; Bourdieu and Passeron, 1990; Reay, 2015; Balmer, Devlin and Richards, 2017).

At the core of Bourdieu's theory is the concept of habitus, the system of internalised dispositions, ways of thinking, acting, and perceiving, that individuals develop through their social upbringing. These dispositions are shaped by early life experiences, particularly within the family and community, and generally reflect the norms and expectations of one's social class (Bourdieu, 1990; Reay, 1998). For working-class students, this often results in a habitus that does not align with the dominant culture of elite educational institutions, causing feelings of dislocation, self-doubt, and symbolic exclusion (Reay, 2015; Balmer et al., 2017). In medical education, institutional habitus, the collective values, expectations, and practices of the institution, frequently mirrors middle-class assumptions, creating a gap for students whose embodied dispositions do not match the expected behaviours and cultural codes of the field (Reay, David and Ball, 2001; Atkinson, 2011). This misalignment can result in what Reay calls 'institutional dissonance' (2005: 86), in which students feel compelled to adapt to survive. However, as Crew (2025) notes, the burden of adjustment is rarely placed on the institution itself, reinforcing the idea that success depends on assimilation rather than structural change.

Building on this, Bourdieu's theory identifies several forms of capital that shape social positioning and access to opportunity. Economic capital comprises financial resources and material assets, while social capital encompasses networks of relationships and connections that provide support and access to resources. Most significant in educational contexts is cultural capital, which includes knowledge, skills, language, and educational credentials that dominant institutions value (Bourdieu, 1986). Bourdieu further differentiates between embodied cultural capital, for example, ways of speaking and mannerisms; objectified capital, for example, access to books, technology and musical instruments; and institutionalised capital, which includes qualifications. In elite educational settings, institutional recognition of certain forms of cultural capital privileges middle-class students, whose dispositions and experiences are more likely to align with institutional expectations (Bathmaker, 2015; Ball et al., 2002). By contrast, working-class students often possess rich forms of embodied cultural capital, such as resilience, practical intelligence, and emotional labour, but these are frequently unrecognised or undervalued in academic settings (Gillies, 2005; Reay, 2004; Loveday, 2015).

To understand how these inequalities are sustained, Bourdieu's concept of symbolic violence offers a particularly powerful analytical tool. Symbolic violence refers to the subtle, often invisible ways in which dominant cultural norms are imposed on marginalised groups, leading them to internalise their subordination (Bourdieu, 1994). In education, this manifests as the privileging of middle-class ways of speaking, behaving, and knowing, which are presented as neutral or universal. Students who do not conform to these norms may experience shame, self-doubt, or a sense of illegitimacy, even when they are academically capable (Reay, 2017; Skeggs and Loveday, 2015). This form of violence is particularly insidious because it operates through consent rather than coercion. It is not simply that working-class students are excluded; rather, they are subtly encouraged to see themselves as less deserving or less capable, thereby reinforcing the very hierarchies that marginalise them (Skeggs, 1997; Reay, 2005). In medical education, where the hidden curriculum often

reinforces elitist assumptions about who belongs and who is likely to succeed, symbolic violence can be especially potent (Brosnan and Turner, 2009; Michalec, 2011).

Taken together, Bourdieu's concepts of habitus, capital, and symbolic violence provide a robust framework for analysing how class-based inequalities are embedded and perpetuated within medical education. They also offer a critical foundation for examining how working-class students experience, negotiate, and sometimes resist the cultural expectations of elite academic environments.

Beyond Deficit: Applying Community Cultural Wealth to Class in Medical Education

Building on Bourdieu's theory of social reproduction, this study applies an adapted version of Yosso's (2005) Community Cultural Wealth (CCW) framework to examine how working-class students navigate and resist inequality in medical education. Developed within Critical Race Theory, CCW challenges deficit-based narratives about racially minoritised students in the U.S. education system. It identifies 'six forms of capital: aspirational, familial, linguistic, social, navigational, and resistant' (Yosso, 2005:69) that students from marginalised communities draw on to survive and succeed in educational institutions that often fail to recognise their value. While Yosso's model was initially rooted in race-conscious analysis, it has since been adapted to examine other forms of inequality, including class, particularly in the UK context (Jackson-Cole and Chadderton, 2025).

This study reinterprets CCW to emphasise class-based inequality, drawing on recent research that applies the framework to working-class students' experiences in elite higher education. Scholars such as Gillies (2005) and Reay (2017) have highlighted how deficit discourses often position working-class students, thereby ignoring the cultural knowledge, emotional labour, and strategic agency they bring to academic spaces. By shifting the analytical focus from what working-class students lack to what they possess, the adapted CCW model offers a more affirming and nuanced account of their educational journeys. This reframing aligns with critiques of meritocracy and the cultural devaluation of working-class identities in higher education (Friedman and Laurison, 2020; Reay, 2017).

Within this adapted framework, aspirational capital is the capacity to sustain hopes and dreams for the future despite structural barriers. For working-class students, this often takes the form of resolve to prove people wrong and to succeed in spaces where they are underrepresented (Loveday, 2015; Shields, 2023). Familial capital comprises the cultural knowledge and emotional support drawn from family and community networks. Values such as perseverance, care, and responsibility, often nurtured in working-class households, serve as motivational anchors that sustain students' persistence (Gillies, 2005; Reay, 1998). Linguistic capital, in this context, comprises the ability to communicate across multiple registers and settings. It may involve the strategic use of accent, tone, and vocabulary to navigate middle-class norms, as well as the emotional labour of code-switching (Jackson-Cole and Chadderton, 2025; Skeggs and Loveday, 2015).

Social capital comprises networks of support that provide access to information, encouragement, and opportunities. For working-class students, this may include mentors, peers, or community figures who help them navigate unfamiliar institutional landscapes (Nicholson and Cleland, 2017). Navigational capital encompasses the skills needed to manoeuvre through institutions not designed with their needs in mind. This includes the

ability to decode hidden rules, access resources, and persist despite exclusion or misunderstanding (Yosso, 2005; Crew, 2025). By contrast, resistant capital comprises the knowledge and strategies used to challenge inequality and assert a person's right to belong. This may involve rejecting deficit narratives, resisting assimilation, or drawing strength from working-class identity and pride (Reay, 2017; Skeggs, 1997).

Alongside these six capitals, Jackson-Cole and Chadderton propose a seventh form, ’perspective capital’ (2025:13), to capture the key insight gained from occupying a liminal position within elite institutions. Perspective capital denotes the capacity to observe and critique dominant norms from the margins and to use this awareness to navigate, oppose, and transform institutional cultures. It is particularly significant for working-class students in medical education, who often develop heightened awareness of class-based assumptions and exclusions and may leverage this insight to champion more inclusive practices (Rollock, 2012; Collins, 1986).

Importantly, these forms of capital are not separate but interconnected. Familial capital may support aspirational and resistant capital, while perspective capital can enhance navigational strategies. These interactions illustrate the complex, dynamic ways in which working-class students mobilise their resources in response to institutional challenges (Reay, Crozier and Clayton, 2009; Jackson-Cole and Chadderton, 2025). Consequently, the adapted CCW framework not only highlights the cultural wealth of working-class students but also challenges the notion that success in medical education requires abandoning working-class identity. Instead, it presents this identity as a source of strength, insight, and professional value, an asset to be recognised rather than a deficit to be overcome.

Class, Capital, and Curriculum: Reimagining Medical Education through Bourdieu and Community Cultural Wealth

The intersection of Bourdieu’s theory of social reproduction and the adapted Community Cultural Wealth (CCW) framework offers a powerful lens for understanding how working-class students experience, navigate, and resist inequality in medical education. Medical schools, particularly in the UK, are often structured around middle-class norms and expectations, both culturally and institutionally. These norms are embedded in what Bourdieu terms the institutional habitus, the values, assumptions, and practices that shape what is recognised as legitimate knowledge, behaviour, and identity within the field (Reay, David and Ball, 2001; Atkinson, 2011). As a result, students from working-class backgrounds often find themselves negotiating a space not designed for their experiences or dispositions.

This negotiation is especially clear in how medical education privileges forms of cultural capital that align with middle- and upper-class backgrounds, such as confidence in professional settings, familiarity with academic discourse, and access to influential networks (Friedman and Laurison, 2020; Reay, 2017). For many working-class students, entering this field with a habitus shaped by different social conditions can lead to what Reay (2015) describes as institutional disconnection, a persistent feeling of not fitting in, even when academically capable. This dissonance is often worsened by symbolic violence, where students internalise the idea that their ways of speaking, dressing, or relating are somehow inferior. Subtle pressures to suppress regional accents, avoid discussing their backgrounds, or adopt behaviours that signal conformity to middle-class norms can undermine confidence and contribute to feelings of not belonging (Skeggs and Loveday, 2015; Loveday, 2015).

Despite these challenges, working-class students also bring a range of cultural resources that can support their success and enrich the profession. The adapted CCW framework helps highlight these often-overlooked forms of capital. Navigational capital, for example, enables students to interpret the hidden curriculum of medical education—such as how to network, seek mentorship, or navigate clinical hierarchies (Yosso, 2005; Crew, 2025). Resistant capital helps students challenge deficit narratives and assert the legitimacy of their backgrounds and perspectives (Reay, 2017; Skeggs, 1997). Perspective capital, as proposed by Jackson-Cole and Chadderton (2025), enables students to reflect critically on structural inequalities within medicine and to advocate for more inclusive practices in both education and patient care. These forms of capital are not merely survival strategies; they are also sources of strength that can enhance students' empathy, communication, and commitment to social justice, qualities increasingly recognised as essential to effective medical practice (Shields, 2023; Baxter et al., 2015).

Furthermore, by combining Bourdieu's and Yosso's frameworks, this study challenges the notion that working-class students must conform to dominant norms to succeed. Instead, it highlights their cultural assets as a valid and valuable contribution to the medical field. This new perspective supports calls to diversify the profession not only in terms of demographics but also epistemologically, by recognising different ways of knowing, relating, and caring (Yosso, 2005; Reay, 2017; O'Sullivan, 2023). It also aligns with wider critiques of meritocracy and emphasises the importance of recognising the structural barriers that influence educational paths (Gillies, 2005; Ball et al, 2002). Ultimately, this framework advocates for a shift from deficit to asset-based approaches within widening participation policies and practices. It underlines the need for institutional change not just to include working-class students but also to acknowledge and adapt to the richness they offer. In doing so, it presents a more inclusive vision for medical education, one that values diversity not as a problem to be managed, but as a resource to be celebrated.

Conclusion

This theoretical framework provides a critical and multidimensional perspective on how class-based inequalities are both perpetuated and challenged within medical education. By combining Bourdieu's theory of social reproduction with an adapted version of Yosso's Community Cultural Wealth (CCW) model, this approach moves beyond deficit-based narratives to highlight the structural barriers and cultural resources that shape the experiences of working-class students.

Bourdieu's (1986) concepts of habitus, capital, and symbolic violence illuminate the institutional mechanisms that favour middle-class norms and marginalise those who do not conform. However, this structural critique is complemented and balanced by the CCW framework, which emphasises the diverse forms of capital, aspirational, familial, linguistic, social, navigational, resistant, and perspective, that working-class students utilise to navigate, challenge, and transform exclusionary educational spaces (Yosso, 2005). This dual approach not only uncovers the tensions and dissonances faced by working-class students in elite medical institutions but also affirms their agency, resilience, and critical insight. It challenges the assumption that success requires assimilation, instead positioning working-class identity as a source of strength and professional value.

Ultimately, the adapted CCW framework not only highlights the cultural wealth of working-class students but also reframes their presence in elite institutions as a source of

transformation. Rather than requiring assimilation, it positions their identities and experiences as valuable contributions to the academic and professional landscape.

Literature Review

The changing nature of social class identity

Class remains a largely unspoken yet profoundly influential force within British society. hooks critiques this silence, arguing that institutions often 'unwittingly support class elitism' (2000: 163), reinforcing structural inequalities through cultural and institutional norms. This misrecognition of working-class experience reflects broader socio-political dynamics that shape how class is lived, represented, and regulated in contemporary Britain (Reay, 2017; O'Sullivan, 2023).

This chapter examines the transformation of working-class identity in the UK, tracing its development from post-war collectivism to modern experiences of marginalisation and resilience. It begins by examining the legacy of deindustrialisation and the dismantling of traditional working-class institutions, drawing on High (2013), Savage et al. (2015), and Dorling (2014) to demonstrate how economic restructuring disrupted the material and symbolic foundations of working-class life. Next, it explores how neoliberalism has reinterpreted class through the perspectives of individual responsibility and meritocracy. Drawing on Bourdieu's (1984, 1990) concepts of habitus, symbolic capital, and symbolic violence, this section examines how inequality is perpetuated through institutional norms and emotional experiences (Reay, 2015; Skeggs and Loveday, 2012).

The chapter then examines the media's role in shaping and reinforcing class-based stereotypes. Media narratives are shown to pathologise working-class life and to justify punitive policies, thereby contributing to symbolic violence and internalised shame (Tyler, 2015; Shildrick, 2018; Scrambler, 2018). Finally, the chapter presents alternative frameworks for understanding class, such as Yosso's (2005) Community Cultural Wealth, which highlights the resilience, care, and cultural capital embedded in working-class communities (Crew, 2025; Jackson-Cole and Chadderton, 2025).

By tracing these developments, the chapter offers a nuanced account of how economic conditions, cultural narratives, institutional practices, and emotional labour shape class identity. It challenges dominant meritocratic discourses and advocates for a more inclusive recognition of working-class lives.

From Industrial Solidarity to Post-Industrial Dislocation

In the post-war period, working-class identity in Britain was deeply rooted in the structures of industrial labour and the social institutions that surrounded it. Employment in industries such as coal mining, steel production, and shipbuilding was not just a source of income but a core part of cultural identity, community cohesion, and political awareness (Hoggart, 1990; Savage et al., 2015). These industries encouraged a collective ethos, strengthened by strong trade unions, working men's clubs, and local civic organisations that provided both social support and a sense of belonging (Hanley 2017; Gilbert 2018). As High (2013) notes, these spaces were central to the visibility and legitimacy of working-class life, offering a shared narrative of dignity and contribution to national prosperity.

However, the onset of deindustrialisation in the late 20th century, accelerated by the Thatcher government's economic policies, caused a significant break in this social fabric. The closure of industrial sites across the UK led to widespread unemployment, economic decline, and the erosion of community infrastructure (Dorling 2014; MacDonald et al., 2020). This process was not only economic but also symbolic: the dismantling of industrial labour undermined the cultural narratives through which working-class people had historically understood their place in society (Pleasant 2019; Savage et al., 2015). The effects of this dislocation were profound. As Tyler (2015) argues, the working class was increasingly portrayed in public discourse not as a productive force but as a social problem. Media depictions and political rhetoric began to frame post-industrial communities as sites of moral failure, dependency, and cultural deficiency (Shildrick 2018; Skeggs 1997).

This symbolic marginalisation was compounded by the spatial concentration of deprivation in former industrial regions, which became stigmatised as left behind or broken (Dorling 2014; Prideaux, 2010). The intergenerational impact of deindustrialisation has been particularly severe. Reay (2017) and Ingram (2009) highlight how younger generations in working-class communities have grown up without the cultural anchors, such as stable employment and community solidarity, that once structured their parents' and grandparents' lives. This has fostered a sense of cultural disorientation and identity fragmentation, as traditional routes to adulthood and respectability have vanished (Walkerdine, 2021; Lehmann, 2014). The loss of these pathways has also contributed to what Skeggs and Loveday (2012) describe as symbolic devaluation, in which working-class ways of being are rendered invisible or deemed inferior within dominant cultural frameworks.

Furthermore, the decline of industrial labour has disrupted the gendered dimensions of working-class identity. As Willis (1977) and Ingram (2009) observe, traditional forms of working-class masculinity, rooted in manual labour and collective resistance, have become particularly unstable, leaving many young men without a clear sense of purpose or belonging in the post-industrial economy. This has contributed to what Reay (2017) terms a crisis of identity and belonging, marked by emotional distress, low self-esteem, and a widespread sense of exclusion.

The shift from industrial solidarity to post-industrial dislocation marks a fundamental change in the material and symbolic dimensions of working-class life in Britain. It has fractured the collective identities that once underpinned working-class culture, replacing them with narratives of individual failure and moral weakness. Understanding this change is vital to any analysis of modern class dynamics, as it reveals the close link between economic change, cultural representation, and emotional experience in shaping and dismantling class-based identities.

Neoliberalism and the Individualisation of Class

The rise of neoliberalism in the UK from the late 1970s has fundamentally reshaped the meaning and experience of class, particularly for working-class communities. Neoliberalism, as both an economic ideology and a cultural framework, promotes individualism, competition, and market logic while systematically dismantling collective welfare systems and public accountability (Bauman, 2009; Livesey, 2019). This ideological shift recasts structural inequalities as matters of personal responsibility, placing sole accountability on individuals for their success or failure amid increasingly unstable social and economic conditions (Gillies, 2005; O'Hara, 2020).

Dorling (2014) argues that neoliberalism has decimated working-class communities by withdrawing state support, eroding public services, and intensifying inequality. Former industrial regions, once sustained by stable employment and collective institutions, have been left to manage the fallout of deindustrialisation with minimal state intervention. This abandonment has not only deepened material deprivation but also contributed to symbolic and emotional dislocation, as communities are stigmatised as culturally deficient and morally suspect.

This process is closely linked to what Reay (2017) and Lawler and Byrne (2005) describe as the individualisation of class. Under neoliberalism, social mobility is framed as an individual project, and failure to achieve it is interpreted as a lack of aspiration or effort. This framing obscures the structural barriers that shape life chances and reinforce the myth of meritocracy (Friedman and Laurison, 2020; Markovits, 2019). As a result, class is rendered both invisible and hyper-visible: denied in public discourse yet reinforced through cultural norms and institutional practices that privilege middle-class values (Walkerdine, 2021; Skeggs and Loveday, 2012). Bourdieu's theory of symbolic power and cultural capital is central to understanding how neoliberalism reproduces inequality. Bourdieu (1984, 1990) argues that dominant groups maintain their position not only through economic means but also by legitimising their cultural practices as superior. In neoliberal contexts, middle-class dispositions, such as confidence, linguistic fluency, and institutional familiarity, are rewarded, while working-class ways of being are devalued or rendered invisible. This symbolic violence operates subtly, shaping perceptions of worth and belonging across education, employment, and public life.

The emotional consequences of symbolic marginalisation are profound. Loveday (2015) and Skeggs (1997) argue that working-class individuals often internalise shame, inadequacy, and exclusion when they cannot conform to middle-class ideals of success. These emotions are not merely personal but are shaped by broader social structures that devalue working-class identities and experiences (Scambler, 2018; Vincent, 2003). Crew (2025) further highlights that these emotional burdens are particularly acute in academic and professional settings, where working-class individuals often feel out of place and unsupported. As Jagger (2025) demonstrates in her analysis of symbolic violence within elite institutions, marginalised professionals frequently internalise dominant norms so deeply that conformity is experienced as a responsibility rather than coercion.

In higher education, neoliberalism's emphasis on self-reliance and competition has contributed to the erosion of collective solidarities. As Addison and Mountford (2014) note, the pressure to perform and conform often leads working-class students to suppress aspects of their identity to fit in, resulting in a form of symbolic erasure in which classed experiences are rendered illegitimate within dominant institutional cultures. In sum, neoliberalism has not only intensified material inequalities but also reshaped the cultural and emotional terrain of class. By promoting individualism and meritocracy, it obscures the structural nature of disadvantage and reinforces the symbolic devaluation of working-class life. Drawing on Bourdieu's framework offers a deeper understanding of how power operates through culture and how inequality is reproduced through everyday practices and institutional norms.

Social Mobility and the Politics of Belonging

A dominant narrative in meritocratic societies holds that upward social mobility requires individuals to distance themselves from their working-class origins. This assumption casts

mobility as a linear progression away from familial, cultural, and community ties, implying that success depends on assimilating to middle-class norms. However, this framing overlooks the complex and often ambivalent experiences of those who navigate new social spaces while maintaining strong ties to their roots (Reay, 2017; Bathmaker et al., 2018; Hanley, 2019).

To challenge this assumption, Reay et al. (2009) demonstrate that mobility does not necessarily entail disconnection. Their research shows that working-class students at prestigious universities often experience a dual sense of identity. Rather than rejecting their backgrounds, many strive to remain connected to their families and communities even as they adapt to unfamiliar institutional cultures. This negotiation of identities reflects what Bathmaker et al. (2018) describe as the 'degree generation', individuals who pursue higher education not to escape their class origins but to improve their circumstances while retaining their values and relationships.

Building on this, Friedman et al. (2021) introduce the concept of the intergenerational self to complicate the notion of mobility as a rupture. They argue that working-class individuals often draw strength and resilience from their family histories, using these narratives to navigate new environments. Rather than viewing their past as a burden, many regard it as a source of identity and purpose, thereby challenging the deficit framing that underpins dominant mobility discourses. Similarly, Nimer (2020) explores how scholarship students experience mobility not as a break from their past but as a reconfiguration of their habitus in response to new conditions of existence. This aligns with Atkinson's (2011) critique of the institutional habitus concept, which he argues must account for the emotional and symbolic attachments that persist across class transitions.

Moreover, Shields (2023) highlights how working-class women in higher education resist assimilation pressures by emphasising their caring responsibilities and emotional labour. These students do not seek to erase their backgrounds but affirm their right to belong on their own terms. Their experiences reveal the emotional complexity of mobility, often marked by guilt, loyalty, and a desire to maintain ties with home rather than sever them. Complementing this, Rickett and Morris (2020) describe how working-class academics navigate emotional labour and belonging within institutions that often fail to recognise their cultural and emotional investments. Similarly, Addison and Mountford (2014) argue that the pressure to 'talk the talk' in higher education settings can silence working-class voices, reinforcing symbolic exclusion even within formally inclusive spaces.

Furthermore, the assumption that mobility equates to cultural abandonment overlooks the structural inequalities that shape access to and experiences of higher education. As Byrom (2009) and Byrom and Lightfoot (2012) demonstrate, working-class students often encounter institutional cultures that are not only unfamiliar but also actively alienating. These environments reward middle-class dispositions and penalise non-conformity, reinforcing the idea that success requires transformation rather than recognition. This is reflected in the work of Clark and Hordosy (2019), who found that working-class students often feel a sense of otherness, even when they succeed academically.

Taken together, these perspectives suggest that social mobility should not be seen as a rejection of working-class life but as a process of navigating multiple identities and spaces. The politics of belonging are central to this experience, as individuals seek recognition not only for their achievements but also for the cultural and emotional resources they bring.

Therefore, a more inclusive understanding of mobility must move beyond assimilation narratives and recognise the legitimacy of working-class attachments, values, and ways of being (Hanley, 2019; Walkerdine, 2021; O'Hara, 2020).

Media, Morality, and the Construction of the 'Underclass'

Media narratives have long shaped public perceptions of the working class, often reinforcing class-based stereotypes and legitimising structural inequalities. One particularly influential example is the 'Broken Britain' trope, which casts poverty, unemployment, and social unrest as moral failings rather than as consequences of systemic disadvantage (Shildrick, 2018; Tyler, 2015). This framing constructs a culturally deficient 'underclass' characterised as irresponsible, dependent, and morally corrupt. As a result, such portrayals obscure the structural causes of inequality and often serve to justify punitive welfare policies (Prideaux, 2010; Cooper & Whyte, 2017).

Building on this, the moral framing of poverty has intensified under neoliberalism, in which a focus on individual responsibility overshadows any notion of collective accountability. As Scrambler (2018) argues, stigma has become a tool of governance, used to discipline and shame those who do not meet ideals of self-sufficiency and productivity. In this context, the media plays a vital role by disseminating images of the working class as irresponsible, criminal, or undeserving, thereby reinforcing social hierarchies and justifying exclusionary policies (Dorling, 2014; Shildrick and MacDonald, 2013).

Moreover, this narrative of individual failure is deeply embedded in neoliberal ideology, which promotes the belief that success is solely the result of personal effort. By contrast, failure is framed as a moral or behavioural deficiency. However, as Bourdieu (1984) and Reay (2015) highlight, this framing overlooks the structural constraints that shape life chances, such as unequal access to education, housing, and employment. It also disregards the role of habitus, the internalised dispositions shaped by one's social environment, which often misalign with the expectations of elite institutions, leading to alienation and exclusion among working-class individuals.

In addition, Skeggs and Loveday (2012) argue that working-class individuals are often judged not for their actions but for their perceived lack of value, a judgement rooted in inherited structural disadvantage. This symbolic devaluation is what Bourdieu (1984) terms symbolic violence: the imposition of dominant cultural norms that render alternative ways of being inferior. The concept of the 'accident of birth' further underscores the arbitrary nature of these inequalities and challenges the meritocratic myth that effort alone determines success (Markovits, 2019; McCoy et al., 2013).

Furthermore, the media's role in this process is not merely representational but also disciplinary. Promoting stories of individual triumph over adversity reinforces the idea that structural barriers can be overcome by grit and determination alone. As a result, those who do not 'succeed' are marginalised, and their struggles are framed as personal failings rather than as outcomes of systemic disadvantage. This narrative, as Reay (2017) and Hanley (2017) contend, contributes to the cultural erasure of the working class, whose values and experiences are dismissed as backward or irrelevant.

From a Bourdieusian perspective, misrecognition operates at the institutional level, where middle-class dispositions are treated as universal and working-class ways of knowing, speaking, and caring are rendered invisible or deemed deficient, thereby normalising

symbolic violence (Reay, 2015; Burawoy, 2019). Internalising these narratives can have profound psychosocial effects. Working-class individuals may come to view themselves as undeserving or inadequate, leading to shame, guilt, and self-doubt (Loveday and Skeggs, 2012). This emotional burden is compounded by the lack of recognition for the forms of capital they do possess, such as resilience, care, and practical knowledge, which are often invisible or devalued within dominant cultural frameworks (Bourdieu, 1986; Crew, 2025).

The media's construction of the 'underclass' individualises failure and obscures the structural conditions that produce inequality. It reinforces a moral hierarchy that privileges middle-class norms. It enables the internalisation of morally defective norms that pathologise working-class lives, thereby sustaining the very inequalities it claims to report on. Bourdieu's (1984) concept of symbolic violence is crucial for understanding how media representations perpetuate class inequality. Symbolic violence refers to the subtle, often invisible ways in which dominant cultural norms are imposed on marginalised groups, leading to the devaluation of their identities and practices. The media, as a key cultural institution, plays a significant role in this process by circulating narratives that pathologise working-class life and uphold middle-class values as the norm (Bourdieu and Wacquant, 2013; Skeggs, 1997).

This symbolic violence is deeply embedded in the structure of neoliberal society, where success is framed as a matter of personal responsibility and failure as a moral failing. As Reay (2015) and Balmer et al. (2017) argue, working-class individuals often experience a misalignment between their habitus, the internalised dispositions shaped by their social environment, and the expectations of elite institutions. This misalignment can lead to alienation, inadequacy, and shame, particularly in settings such as education and healthcare, which are dominated by middle-class norms (Bathmaker, 2015; Friedman and Laurison, 2020).

Moreover, symbolic violence operates through what Bourdieu (1990) describes as the acceptance of dominant values, which are so deeply embedded in the social fabric that they appear natural or inevitable. Media narratives reinforce this doxa by presenting middle-class lifestyles as aspirational and working-class realities as deviant or deficient. This process not only legitimises inequality but also obscures the structural mechanisms that produce it (Dorling, 2014; Livesey, 2019). Importantly, the media's construction of the 'underclass' is not only classed but also gendered and racialised. Tyler (2015) highlights how single mothers, migrants, and racialised communities are disproportionately targeted in media narratives, reinforcing intersecting forms of stigma. These portrayals divide the working class, pitting groups against each other and deflecting attention from the structural causes of inequality. This aligns with Sennett and Cobb's (1973:89) concept of the 'hidden injuries of class', the emotional wounds inflicted by a society that devalues certain lives while celebrating others.

Furthermore, symbolic violence is internalised, shaping how individuals perceive themselves and their place in the world. As Loveday (2015) and Skeggs and Loveday (2012) demonstrate, working-class individuals often experience shame and self-doubt because they are judged against middle-class standards they were never meant to meet. This internalisation of inferiority is a powerful mechanism of social control, discouraging resistance and reinforcing compliance with the status quo. This is particularly evident in educational contexts. Students from working-class backgrounds may lack the cultural capital that aligns with institutional expectations, leading to their marginalisation despite their

capabilities (Reay, 2004; Ball et al., 2002). The media reinforces this by celebrating stories of exceptionalism, those who 'escape' their class background, while ignoring the systemic barriers that prevent most from doing so (Hanley, 2017; O'Hara, 2020).

In sum, symbolic violence enacted through media representations is a central mechanism in the reproduction of class inequality. It legitimises exclusion, masks structural disadvantage, and disciplines those who deviate from dominant norms. To challenge this, it is essential to expose the ideological underpinnings of media narratives and to foreground the lived experiences and cultural resources of working-class communities.

Reframing the Narrative of Working-Class Life

The dominant discourse surrounding working-class communities often frames them through a deficit lens, portraying them as culturally lacking, morally suspect, and inherently disadvantaged. However, this narrative overlooks the complex, resourceful, and resilient ways in which working-class individuals navigate and resist structural inequality. Scholars such as Skeggs (1997) and O'Hara (2020) have demonstrated that working-class individuals are not passive victims of symbolic violence, but rather active agents who reinterpret imposed labels through alternative value systems rooted in care, solidarity, and mutual support.

To move beyond deficit-based models, Yosso's (2005) Community Cultural Wealth (CCW) framework offers a transformative perspective. Drawing on Critical Race Theory, Yosso identifies six forms of capital, namely aspirational, linguistic, familial, social, navigational, and resistant, that are often unrecognised within traditional sociological frameworks. These forms of capital challenge Bourdieu's (1986) institutionalised conception of capital by foregrounding the lived experiences and cultural strengths of marginalised communities. Navigational capital, for instance, enables students to navigate institutions not designed for them, while resistant capital reflects their determination to challenge exclusionary norms. Familial and social capital provide emotional grounding and a sense of identity that can counteract the alienation often experienced in elite educational and professional spaces (Loveday and Skeggs, 2012; Crew, 2025).

For many working-class people, care is not merely a personal or emotional act; it is a deeply embedded cultural practice shaped by classed experiences, moral values, and social expectations. As Skeggs (1997) and Hochschild (2003) argue, care is a form of labour that is both emotional and relational, often performed by working-class women in ways that dominant institutions undervalue. This labour is not only about meeting needs but also about sustaining relationships, affirming dignity, and enacting moral responsibility. In working-class communities, care is often collectivised and reciprocal. Gillies (2005) shows how working-class mothers engage in practices of 'distributed parenting', in which care is shared across extended family and community networks. This contrasts with middle-class models of intensive, individualised parenting and reflects a broader ethic of mutual support. These practices are not only adaptive responses to material constraints but also expressions of cultural identity and social solidarity.

Moreover, care in working-class contexts is often imbued with moral meaning. Halewood (2023) suggests that working-class moral economies are grounded in values such as loyalty, fairness, and responsibility, which are enacted through everyday acts of care. These practices challenge neoliberal ideals of self-sufficiency and competition, offering instead a

vision of social life rooted in interdependence and compassion. Furthermore, Potter et al. (2018) document how individuals living with long-term conditions in economically deprived areas rely on informal care networks that are emotionally rich and culturally embedded. These networks are not merely compensatory but central to how people understand and enact wellbeing.

Compassion as Resistance to Neoliberalism

In a society that increasingly equates worth with productivity and self-sufficiency, working-class compassion can be understood as a form of moral and cultural resistance. Neoliberalism promotes a competitive individualism that privileges self-interest and market logic, often at the expense of collective wellbeing (Bauman, 2009; Livesey, 2019). In this context, acts of care and empathy, particularly when extended beyond the nuclear family, become countercultural. They challenge the dominant narrative that success is solely the result of personal effort and that failure reflects individual deficiency.

Hanley (2017) and Reay (2017) emphasise that working-class communities sustain a sense of shared responsibility and mutual aid, even amid economic hardship and cultural devaluation. These practices are not merely survival strategies but expressions of a moral economy that prioritises solidarity over self-interest. They reflect what Halewood describes as a ‘classed moral habitus’ (2023:127), a set of ethical dispositions rooted in lived experience and collective struggle. For example, Reay (2005) documents how working-class families in London schools supported one another through informal childcare, shared meals, and emotional solidarity. These practices directly counter the isolating effects of neoliberal individualism, demonstrating that compassion is embedded in everyday life. They also reveal how working-class people create alternative systems of value and recognition that are often invisible to, or dismissed by, dominant institutions.

Similarly, Shields (2023) highlights that working-class women in higher education emphasise their caring responsibilities not as burdens but as sources of strength and identity. Rather than conforming to institutional expectations of detachment and self-promotion, these women assert their right to belong on their own terms, bringing a relational ethic that values care, emotional labour, and community connection. Further evidence of compassion as resistance appears in Crew’s (2025) study of working-class academics, who often provide informal mentoring, emotional support, and advocacy for marginalised students. These acts of care are rarely recognised or rewarded by institutions, yet they are vital to others’ well-being and inclusion. In this sense, compassion becomes a form of ‘quiet activism’, a way of challenging exclusionary norms through everyday practices of solidarity and support.

Moreover, this ethic of care often extends beyond the immediate community. During the COVID-19 pandemic, for instance, mutual aid groups, many rooted in working-class neighbourhoods, mobilised rapidly to provide food, medicine, and emotional support to vulnerable residents. These grassroots responses stood in stark contrast to the often slow, bureaucratic institutional responses, highlighting working-class communities' capacity to act collectively and compassionately in times of crisis (Mawson, 2022). Working-class compassion is not a passive or sentimental quality. It is an active, relational, and often political stance that resists the dehumanising logics of neoliberalism. It affirms the value of interdependence, challenges the moral hierarchies of meritocracy, and sustains communities in the face of structural neglect.

Community as Cultural Wealth

The concept of community within working-class life is often reduced to nostalgic imagery or framed as a compensatory mechanism for economic deprivation. However, when viewed through a critical lens, particularly through Yosso's (2005) Community Cultural Wealth (CCW) framework, community emerges not as a residue of loss but as a dynamic site of cultural production, resistance, and identity formation. Rather than accepting dominant definitions of capital that privilege middle-class norms, CCW foregrounds the value of relational, affective, and resistant practices cultivated within marginalised communities.

In working-class contexts, community is not simply a geographic or social container but a lived structure of feeling, in which care, solidarity, and mutual recognition are enacted daily. These practices are not incidental; they are deeply embedded in the moral economies of working-class life. As Skeggs (1997) argues, working-class value systems are often constructed through relationships and responsibilities to others, rather than through accumulation or individual advancement. This relational ethic is not only a cultural resource but also a form of symbolic resistance to neoliberal logics that equate worth with autonomy, productivity, and institutional recognition.

Empirical studies reinforce this understanding. Crew (2025) illustrates how working-class academics, often marginalised within elite institutions, rely on informal support networks, peer mentoring, emotional solidarity, and collective advocacy to navigate spaces not designed for them. These networks are not merely coping mechanisms; they are expressions of resistant capital that challenge the exclusionary norms of academic culture. Similarly, Jackson-Cole and Chadderton (2025) show how minoritised working-class students draw on intergenerational narratives and community ties to sustain their sense of self in elite postgraduate environments. These forms of cultural wealth are not only adaptive but also transformative, enabling individuals to reframe their presence as legitimate and valuable.

What is often dismissed as parochial or insular, such as tight-knit kinship networks, localised knowledge, and shared histories, can instead be understood as forms of familial and social capital that provide emotional grounding and practical navigation through hostile systems. These are not static inheritances but active, cultivated practices that reflect a collective investment in survival and dignity. As Reay (2005) and Gillies (2005) demonstrate, working-class families often engage in distributed caregiving and mutual aid, practices that are both materially necessary and symbolically rich. These practices constitute a form of cultural labour that is rarely acknowledged in dominant discourses but is central to the reproduction of community and identity.

Moreover, sustaining community in the face of structural neglect, through food banks, mutual aid groups, or informal childcare networks, can be read as a form of resistant cultural production. These practices do not simply fill the gaps left by the state; they articulate alternative logics of value, care, and belonging. In Bourdieu's terms, they constitute a refusal of symbolic violence, a way of asserting worth in a system that routinely denies it. Thus, community in working-class life is not a passive backdrop but an active, generative force. It is where cultural wealth is created, shared, and defended. It is where care becomes political, where solidarity becomes strategy, and where identity is not only preserved but reimagined.

This chapter has critically examined the transformation of working-class identity in contemporary Britain, revealing how economic restructuring, neoliberal ideology, and cultural representation have reshaped the material, symbolic, and emotional dimensions of class. Through a synthesis of sociological theory and empirical research, it has demonstrated that working-class identity is not a static or residual category but a dynamic and contested terrain, continually redefined through processes of marginalisation, resistance, and revaluation.

The legacy of deindustrialisation marked a profound rupture in the social fabric of working-class life, dismantling not only economic stability but also the cultural institutions and collective identities that once underpinned working-class solidarity. This dislocation was compounded by the rise of neoliberalism, which reframed structural inequality as personal failure and promoted a meritocratic discourse that obscures systemic disadvantage. Drawing on Bourdieu's concepts of habitus, symbolic capital, and symbolic violence, the chapter has shown how these ideological shifts have produced both material exclusion and deep emotional injuries, manifested in shame, alienation, and the internalisation of inferiority.

Media representations have played a central role in legitimising these inequalities, casting the working class as morally deficient and culturally deviant. These narratives not only reinforce symbolic violence but also discipline working-class individuals into accepting their marginalisation as natural or deserved. Yet, as the chapter has argued, these dominant discourses are neither totalising nor uncontested.

By engaging with alternative frameworks such as Yosso's Community Cultural Wealth, the chapter has foregrounded the cultural agency, collective care, and everyday strategies of endurance embedded within working-class communities. Practices of mutual aid, emotional solidarity, and intergenerational support are not merely coping mechanisms but forms of cultural labour and political expression that challenge neoliberal values and reassert the legitimacy of working-class ways of being. Far from being sentimental or apolitical, compassion and care emerge as moral and cultural practices that sustain community and identity in the face of structural neglect.

Ultimately, this analysis calls for a reframing of working-class identity, one that moves beyond deficit models and recognises the complex interplay of economic conditions, cultural narratives, institutional practices, and emotional experiences. It demands a shift in sociological and political discourse: from pathologising working-class life to valuing its contributions, from individualising failure to exposing structural injustice, and from symbolic erasure to cultural recognition. Only through such a reframing can we begin to address the enduring inequalities that shape class in twenty-first-century Britain.

Educational Inequality in Compulsory Schooling

Four years after publishing Learning to Labour in 1977, Paul Willis offered a sobering reflection on the socio-economic conditions of early 1980s Britain:

> Unemployment is over 10 per cent… most affected are the young, unskilled, low-qualified early school leavers. With structural changes in the economy proceeding apace, many jobs may never reappear (Willis, 1981:247).

Although over forty years have passed since this statement was made, its relevance remains stark in the context of contemporary Britain. The combined effects of globalisation, deindustrialisation, austerity, Brexit, and the COVID-19 pandemic have intensified structural inequalities, particularly for working-class and ethnic minority communities (Dorling, 2014; Cooper and Whyte, 2017; Marmot et al., 2020).

Willis' ethnographic study was groundbreaking in its exploration of how working-class youth, despite being aware of the limited prospects available to them, actively participated in reproducing their class position. His work challenged deficit models of educational failure by highlighting the cultural and institutional mechanisms that shape educational trajectories. Since then, a substantial body of research has built upon this foundation, examining how education systems continue to reproduce social hierarchies through curriculum, pedagogy, assessment, and access to opportunity (Ball, 2005; Reay, 2017; Bathmaker et al., 2018).

In the decades following Willis' study, successive governments have introduced policies aimed at widening participation in higher education and promoting social mobility. These initiatives have included outreach programmes, financial support, and institutional targets for diversity (Milburn, 2012; Department for Education, 2024). However, despite these efforts, significant disparities persist in educational access, experience, and outcomes. Students from working-class backgrounds remain underrepresented in elite universities and high-status professions. When they do gain access, they often face cultural and institutional barriers that hinder their success (Friedman and Laurison, 2020; Reay, 2017).

Thus, educational inequality in Britain begins long before students reach higher education. Compulsory schooling, intended as a universal foundation for opportunity, often functions instead as a mechanism for reproducing social class. For working-class young people, the school system presents a series of structural, cultural, and symbolic barriers that constrain their educational pathways and reinforce existing inequalities. One of the most enduring structural features of the British education system is its stratification. Schools are divided into tiers that reflect and reproduce social hierarchies. Ball (2013:47) describes post-war education as built on 'methodologies of division and differentiation,' while Slee and Weiner (1998:3) argue that mass education was designed to prepare children for their 'eventual work and class destination'. This legacy persists today through selective schooling, private education, and postcode-based admissions, which disproportionately benefit middle-class families. As Reay (2017:15) notes, working-class students are often positioned 'at the bottom of a hierarchy of value and respect'.

This structural inequality is compounded by unequal access to high-quality schools. Middle-class parents often draw on their economic and cultural capital to secure places in high-performing institutions, including through strategic relocation or religious affiliation (Ball, Bowe et al., 1992; Reay, 1998). By contrast, working-class families are more likely to be assigned to under-resourced schools, where teacher turnover is high, expectations are lower, and access to enrichment opportunities is limited (Reay, 2017; Gilbert, 2018).

The rhetoric of parental choice often obscures these disparities. Neoliberal education reforms have promoted the idea that competition and choice foster school improvement. However, as Bauman (2009:72) observes, 'the conditions under which choices are made are not themselves a matter of choice'. Reay (2017) and Ball (2005) argue that the education system rewards those who already possess the knowledge and resources to navigate it, thereby reinforcing privilege. The illusion of meritocracy obscures the structural

disadvantages that shape educational outcomes from the earliest stages. This illusion is particularly harmful because it shifts responsibility for success or failure onto individuals. This expectation unfairly burdens working-class students, who must overcome systemic barriers without the institutional support available to their more privileged peers.

The consequences of these early inequalities are evident in measurable outcomes. Educational disadvantage is apparent from the earliest years of schooling. Children from low-income households are twice as likely to start school with underdeveloped language and communication skills (Ball et al., 2002). These early deficits have long-term effects on academic performance, confidence, and engagement. By the time students reach GCSE level, the attainment gap is stark: in 2024, only 45% of pupils eligible for free school meals achieved a grade 5 or above in English and Maths, compared with 71% of their non-FSM peers (Sutton Trust, 2025).

Beyond academic performance, cultural misrecognition significantly shapes the experiences of working-class students. Bourdieu's concept of habitus explains how students internalise the norms and values of their social environment, which may conflict with the dominant culture of educational institutions (Bourdieu, 1990; Atkinson, 2011). This mismatch can result in symbolic violence, subtle forms of exclusion and devaluation that undermine students' confidence and sense of belonging. As Reay (2017:122) argues, the education system 'misrecognises and rewards the benefits of a privileged class background,' while Gilbert (2018: 89) highlights how working-class students often feel 'unseen, misunderstood and out of place'.

These feelings are exacerbated by the narrowing of the curriculum in schools serving disadvantaged communities. In such contexts, the focus is often on basic skills and exam preparation, to the detriment of creativity, critical thinking, and cultural enrichment. Hanley (2017:36) argues that working-class students are 'schooled to reach a certain level of understanding and no higher'. This reflects a deficit model of education, in which low expectations become self-fulfilling prophecies.

Finally, teacher expectations and institutional biases further entrench inequality. Teachers may hold unconscious assumptions about students' abilities and aspirations based on class background. Reay (2017:145) notes that many working-class children 'give up on the intense and unfair competition that education has become,' not because they lack ability, but because the system fails to recognise and nurture their potential.

The Illusion of Choice and Structural Constraints

The British education system has long functioned as a mechanism of social stratification. Historically, it has been structured to reinforce existing class hierarchies rather than dismantle them. Ball (2013:47) describes post-war schooling as built on 'methodologies of division and differentiation,' a sentiment echoed by Slee and Weiner (1998:3), who argue that mass compulsory education was initially designed to prepare children for their 'eventual work and class destination'. This structural intent remains embedded in contemporary schooling, where working-class students are often positioned 'at the bottom of a hierarchy of value and respect' (Reay, 2017:15).

The emergence of neoliberal reforms in the late 20th century heightened the influence of market forces in education. These reforms championed a narrative centred on parental choice, competition, and accountability, which aimed to improve standards but deepened

inequality (Ball, 2005; Tomlinson, 2005). The idea of choice, fundamental to neoliberal ideology, is presented as a neutral and empowering tool. However, as Bauman (2009:72) notes, ‘the conditions under which choices are made are not themselves a matter of choice’. This observation is vital to understanding how the illusion of choice conceals the structural constraints faced by working-class families.

Middle-class families, equipped with economic, cultural, and social capital, are better able to navigate the education system. They often engage in strategic behaviours such as relocating to areas with high-performing schools, leveraging social networks, or even adopting religious affiliations to secure school places (Ball, Bowe et al., 1992; Reay, 1998). These practices are not merely individual strategies but are embedded within a broader system that rewards familiarity with the rules of engagement, a concept central to Bourdieu’s theory of social reproduction (Bourdieu, 1990; Jenkins, 1992). Hanley (2017:35) captures this disparity succinctly: ‘for the powerful, excellence in education and culture is both a demand and a right. For the powerless, excellence must be self-generated because it is not otherwise expected’. This distinction underscores the unequal distribution of resources and expectations. Reay (2017:122) argues that the education system ‘misrecognises and rewards the benefits of a privileged class background,’ thereby reinforcing existing hierarchies under the guise of meritocracy.

The myth of meritocracy is further problematised by conflating academic success with innate ability. Reay (2017:141) critiques the assumption of ‘natural brightness’ among middle-class students, highlighting instead the ‘carefully constructed and intensively nurtured’ environments that facilitate their success. Similarly, Friedman and Laurison (2020:24) emphasise that success often results from ‘using all of the resources at a person’s disposal,’ rather than from individual talent alone. This systemic advantage is not equally available to working-class and ethnic minority students, whose educational choices are often constrained by limited access to high-quality schools, financial insecurity, and a lack of institutional support. As Watson (in Gilbert, 2018:19) notes, ‘advantage has inherent mobility,’ whereas disadvantage is often static and self-reinforcing. Reay (2017:142) describes the education system as one that ‘caters for winners’ while simultaneously ‘reinforcing and solidifying the position of losers’. Despite political rhetoric that frames education as a vehicle for social mobility, structural inequalities remain deeply entrenched.

Forrester and Garrett (2012:13) observe that although successive governments have claimed that ‘equality of opportunity’ drives education policy, the system’s growing privatisation and stratification suggest otherwise. Further, Hooks (2000:65) critiques the myth of a classless society, arguing that such narratives obscure the real barriers marginalised groups face. The rhetoric of meritocracy and equal opportunity often obscures the structural nature of educational inequality. As Bauman (2009) and Reay (2017) argue, the notion that individuals succeed or fail solely on effort and ability overlooks the profound influence of social class, race, and geography. Moreover, the expansion of higher education has not necessarily translated into equitable outcomes; rather, it has often reinforced existing hierarchies by stratifying institutions and degrees (Wakeling and Savage, 2015).

The consequences of these structural inequalities are profound. Many working-class students become disillusioned with a system that fails to recognise their potential or support their aspirations. Reay notes that ‘many working-class children give up on the intense and unfair competition that education has become’ (2017:145). Brown (in Gilbert, 2018:52)

further highlights how feelings of being ‘unseen, misunderstood and out of place’ can erode students’ confidence and engagement. As Reay (2017:114) asserts, ‘in 21st Century England, social, political and economic inequalities have been transformed into educational inequalities that then become the responsibility of the individual’. This shift from structural to individual blame not only obscures the root causes of inequality but also places an undue burden on those least equipped to bear it.

The concept of belonging is central to understanding educational inequality. Clark and Hordosy (2019:355) found that students’ sense of belonging strongly influences their likelihood of remaining in higher education. Reay (2006:523) describes the ‘lack of fit’ between working-class habitus and the middle-class field of higher education as a source of uncertainty and anxiety. Institutional cultures often reflect and reinforce middle-class norms, creating barriers for students from non-traditional backgrounds. Reay (2017:136) documents instances of overt class-based discrimination, such as derogatory comments on student forums. These practices foster a sense of exclusion and reinforce the perception that working-class students do not belong.

COVID-19 and the Exposure of Educational Inequality

The hidden curriculum, the unwritten rules and expectations within educational institutions, further marginalises students who lack the cultural capital to interpret them (Cribb and Bignold, 1999; Michalec, 2011). Bourdieu and Passeron (1994:13) argue that ‘misunderstanding and the fiction that there is no misunderstanding are inseparable phenomena’. This insight underscores the need for institutions to critically reflect on their practices and assumptions. Without such reflection, efforts to widen participation risk reinforcing rather than challenging existing inequalities.

The COVID-19 pandemic served as a stress test for the UK education system, revealing and amplifying deep-seated structural inequalities that had long existed but were often overlooked. Far from being a universal disruption, the pandemic’s impact was profoundly unequal, disproportionately affecting students from working-class backgrounds. As Mawson (2022) powerfully articulates, many of these students were already 'lost before lockdown', excluded by a system that failed to accommodate their needs, aspirations, or lived realities. The pandemic did not create these inequalities; it made them more visible and more acute.

The abrupt shift to remote learning exposed a stark digital divide. While some students could continue their education with minimal disruption, others lacked access to basic technological resources, including laptops, reliable internet, and quiet study spaces (Sutton Trust, 2025; Greenhalgh et al., 2004). These disparities were not merely about devices; they reflected broader socio-economic inequalities rooted in housing, income, and parental support. For many working-class students, school had been a source of stability, structure, and support. Its closure meant the loss not only of teaching but also of essential services, such as free meals, mental health support, and safeguarding (Bathmaker et al., 2018; Reay, 2017).

The A-level grading crisis of 2020 further revealed the class-based nature of educational assessment. The algorithm used to assign grades relied on historical school performance, which systematically disadvantaged students from under-resourced schools, many from working-class communities, while favouring those from high-performing, often fee-paying institutions (Kolkman, 2020). Mawson (2022) criticises this as a form of institutionalised injustice, in which the state’s dependence on statistical modelling effectively erases

individual effort and reinforces existing hierarchies. The public outcry and subsequent policy reversal exposed the vulnerability of meritocratic ideals in the face of systemic bias.

Beyond academic outcomes, the pandemic also disrupted the emotional and psychological trajectories of working-class students. Isolation, uncertainty, and the loss of routine contributed to heightened anxiety, disengagement, and, in some cases, permanent withdrawal from education (Looseley et al., 2019; Moir et al., 2018). These effects were compounded by the intergenerational nature of disadvantage, in which educational failure is both a consequence and a cause of broader socio-economic exclusion (MacDonald, Shildrick and Furlong, 2020; Shildrick, 2018). COVID-19 did not simply interrupt education; it revealed the extent to which the system is structured around middle-class norms and assumptions. It exposed the limits of digital solutions in addressing inequality and challenged the notion that education is a level playing field.

The literature highlights that educational institutions, far from being neutral spaces, are implicated in reproducing social hierarchies. Bourdieu's concepts of habitus and field provide a helpful framework for understanding how students from different class backgrounds navigate educational environments that may or may not align with their lived experiences (Atkinson, 2011; Reay et al., 2001). Moreover, the emotional and psychological toll of navigating these spaces, often marked by symbolic violence and misrecognition, further compounds the challenges faced by working-class learners (Skeggs and Loveday, 2012; Loveday, 2015). This review draws on these theoretical and empirical insights to explore how educational inequality is sustained through both overt and covert mechanisms, and how working-class students resist, adapt to, or are marginalised by these dynamics.

Despite decades of policy interventions to promote social mobility and widen participation, educational inequality in the UK remains deeply entrenched along class lines. Recent data show that students from the most advantaged areas are still more than twice as likely to enter higher education as those from the most disadvantaged areas (Sutton Trust, 2025). This persistent gap reflects not only disparities in academic attainment but also broader structural inequalities that shape educational trajectories from early childhood through to post-compulsory education.

The attainment gap at GCSE level remains a stark indicator of this divide. In 2024, only 45% of pupils eligible for free school meals (FSM) achieved a grade 5 or above in English and Maths, compared with 71% of their non-FSM peers. This disparity is not merely a reflection of individual ability or school quality but is rooted in socio-economic disadvantage, including limited access to cultural capital, unstable housing, and lower parental educational attainment (Reay, 2004; Bourdieu, 1986). As Ball (2005) argues, education policy often fails to address these underlying inequalities, instead focusing on performativity and accountability measures that disproportionately penalise schools serving disadvantaged communities.

The fallout from the grading crisis was unevenly distributed. Students at private schools were significantly more likely to have their grades upheld or even inflated, whereas many state school students, particularly those from disadvantaged backgrounds, were downgraded, jeopardising their university places and future opportunities (Montacute and Cullinane, 2018; Sutton Trust, 2025). The public backlash and eventual policy reversal underscored how poorly the system had accounted for the lived realities of educational inequality. As Dorling

(2014) and Reay (2017) have shown, such crises do not create inequality; they expose and intensify it.

This episode must be understood within the broader context of elite university admissions. The dominance of private-school students at institutions such as Oxford and Cambridge remains a powerful symbol of entrenched privilege. Despite representing only 7% of the school population, private-school students account for over 30% of Oxbridge admissions (Sutton Trust, 2025). This overrepresentation reflects not only academic advantage but also access to social networks, cultural capital, and institutional support that are inaccessible to their state-educated peers (Ball et al., 2002; Skeggs and Loveday, 2012). As Power et al. (2003) argue, the education system is structured to reward those who already possess the 'right' forms of capital, while systematically excluding others.

Critically, the persistence of these inequalities challenges the legitimacy of meritocratic narratives that underpin much of UK education policy. As Markovits (2019) and Friedman and Laurison (2020) argue, the rhetoric of equal opportunity often masks the reproduction of privilege, shifting the blame for failure onto individuals rather than addressing systemic barriers. The A-level grading fiasco exemplifies this dynamic: a policy intended to ensure fairness instead reinforced existing hierarchies, exposing how deeply classed assumptions are embedded in the architecture of educational assessment. As Livesey (2019) and Tyler (2015) note, neoliberal education reforms have increasingly individualised responsibility while depoliticising structural inequality, making it harder to challenge the systemic reproduction of class advantage.

The system's alignment with middle-class norms and expectations further entrenches inequality. Bourdieu's theory of cultural capital (1986) explains how students from privileged backgrounds possess linguistic styles, behaviours, and dispositions that are recognised and rewarded by educational institutions. In contrast, working-class students often experience a mismatch between their own habitus and the institutional habitus of schools and universities (Atkinson, 2011; Reay et al., 2001), leading to symbolic violence, which comprises subtle, often invisible forms of exclusion and devaluation (Bourdieu and Wacquant, 2013; Skeggs and Loveday, 2012).

Conclusion: From Inequality to Inclusion

This review has demonstrated that educational inequality in Britain is not the result of individual deficits or a lack of potential among working-class students, but rather the outcome of deeply embedded structural barriers and institutional biases. The enduring stratification of the education system, through selective admissions, curriculum narrowing, and cultural misrecognition, continues to reproduce class-based disadvantage. As the literature consistently shows, working-class students are not inherently less capable; rather, they are systematically denied the opportunities, resources, and recognition afforded to their more privileged peers.

The concept of poverty of opportunity is central to understanding this dynamic. It reframes educational inequality not as a failure of individuals but as a systemic denial of access to the conditions necessary for success. From early years education through to post-16 transitions, working-class students face cumulative disadvantages, including limited access to high-quality schools, under-resourced learning environments, and institutional cultures that fail to affirm their identities. These are not isolated issues but interconnected features of a system that privileges those already equipped with cultural and economic capital.

Symbolic violence further entrenches this inequality by subtly devaluing working-class students' ways of speaking, behaving, and knowing. Through the hidden curriculum and everyday interactions, students internalise messages that their backgrounds are inferior or out of place. This misrecognition not only undermines confidence and a sense of belonging but also reinforces the very hierarchy that education claims to dismantle. The COVID-19 pandemic laid bare the fragility of meritocratic ideals. The digital divide, algorithmic grading, and the withdrawal of school-based support disproportionately harmed those already disadvantaged, revealing how deeply inequality is embedded in the structure of education. These events did not create new injustices; they exposed and intensified existing ones.

Therefore, the findings of this chapter challenge the idea that education is a neutral or equalising force. Instead, they expose a system that consistently reproduces inequality, dressed up as fairness and merit. Recognising poverty of opportunity as a structural condition, rather than a personal failing, is vital to any genuine critique of educational inequality. Only by confronting these ingrained injustices can we begin to envision a more equitable and inclusive future for education.

Working-class families in Britain consistently demonstrate a deep commitment to their children's futures, often fuelled by pride, resilience, and aspiration. Contrary to deficit narratives that cast these families as disengaged or lacking ambition, research shows they actively strive to secure better educational outcomes for their children (Gillies, 2005; Reay, 2017). However, their efforts are often constrained by structural inequalities that limit access to the resources, networks, and institutional knowledge that middle-class families routinely draw on.

Contemporary UK policy often reframes class inequality as a matter of parenting style, casting working-class parents as deficient in emotional and cultural resources. This framing promotes a coercive model of support characterised by surveillance, discipline, and moral judgement, while idealising middle-class parenting as the normative standard (Montacute and Cullinane, 2018; Friedman and Laurison, 2019). Parenting becomes a moral project, in which working-class families are scrutinised not only for what they do but for who they are. These narratives obscure the material constraints faced by working-class families and reinforce institutional biases that privilege middle-class norms.

This dynamic is deeply rooted in neoliberal ideology, which individualises responsibility and frames education as a competitive market. Within this framework, parents are expected to act as strategic agents, maximising their children's life chances through informed choices and resource mobilisation. However, as Bourdieu (1977) and Reay (2017) argue, working-class families are structurally disadvantaged in this competition. They often lack access to the cultural and social capital that middle-class families use to navigate the education system, including informal networks, insider knowledge, and financial flexibility. The Sutton Trust's Parent Power report (Montacute and Cullinane, 2018) illustrates how middle-class parents strategically deploy their capital by moving to desirable catchment areas, using relatives' addresses, and funding private tuition to secure educational advantages. By contrast, working-class parents, who may be equally aspirational, are often limited to local schools and informal advice, navigating an opaque and exclusionary system. This disparity exemplifies Bourdieu's theory of social reproduction, in which the educational system rewards middle-class capital while marginalising working-class knowledge and values.

Despite these barriers, working-class families continue to demonstrate aspirational capital, a concept central to Yosso's (2005) Community Cultural Wealth (CCW) framework. Aspirational capital is the capacity to sustain hope and ambition despite structural adversity. Working-class parents instil values such as perseverance, authenticity, and solidarity, qualities that are not always recognised by educational institutions but are vital to personal and community resilience. These forms of capital challenge deficit models and highlight the strengths that working-class communities bring to educational spaces. However, the education system's failure to recognise and reward these forms of capital perpetuates a cycle of exclusion. As Crew (2025) argues, institutions must move beyond tokenistic inclusion and begin to value the diverse experiences and strengths that working-class students and families bring. This requires a shift from a meritocratic ideal to a more equitable model that acknowledges the systemic nature of inequality and the legitimacy of working-class cultural wealth.

To conclude, working-class families want better for their children, not in abstract terms but through concrete acts of care, sacrifice, and hope. Their struggle is not about motivation but about access. Without structural change, the education system will continue to reward those who already have the tools to succeed, while marginalising those who must work twice as hard for half as much. Recognising and valuing working-class pride and aspiration is essential to building a more inclusive and just educational landscape.

Clash of the Habitus: Middle-class University– Working-class students

Bourdieu's (1977) concept of habitus refers to the deeply ingrained habits, skills, and dispositions that individuals develop through their life experiences, fundamentally shaping their perceptions and reactions to the world. These experiences leave 'long-lasting dispositions of the body and mind' (Bathmaker, 2018: 23). The concept of habitus offers a lens for understanding the working class beyond their socioeconomic background. The challenges faced by the working class when entering higher education and professional careers arise not only from limited financial resources but also from the effects of inequality on individual confidence and well-being. Class remains an unspoken yet profoundly influential force within educational institutions. Hooks critiques this silence, arguing that universities often 'unwittingly support class elitism' (2000:163), thereby reinforcing structural inequalities through cultural and institutional norms.

This misrecognition of working-class experience is not confined to education but reflects broader socio-political dynamics that shape how class is lived, represented, and regulated in modern Britain (Reay, 2017; O'Sullivan, 2023). Hooks (2000) discusses the silence surrounding class as part of the problem, highlighting the lack of recognition of the challenges faced by working-class students, meaning that universities 'unwittingly support class elitism' (hooks, 2000:163). The fact that class inequalities are not addressed under the Equality Act 2010 means universities are neither measured nor compelled to consider social class. As hooks (2000) suggests, this silence leads to the misrecognition of class inequality.

However, class background significantly influences habitus, affecting individuals' attitudes, behaviours, and expectations. Additionally, interactions with institutions, such as schools, the NHS, and the criminal justice system, further shape this concept, often positioning working-

class individuals as recipients of services rather than contributors. Moreover, education plays a crucial role in developing the habitus of young people. The marketisation of education has exacerbated inequalities, with the quality of a child's school, their neighbourhood, and the occupations of their primary caregivers critically determining the opportunities available to them (Reay, 2015; Hanley, 2019). Consequently, the Office for Students (OfS), established in 2018, regulates universities to widen access and rethink admissions. Universities are encouraged to consider applicants' socioeconomic circumstances, not just academic qualifications, a practice known as contextualised admissions. This method examines factors such as school quality, home support, personal challenges, and socioeconomic background to promote fairness and give disadvantaged students a better chance of admission (UCAS, 2020; Boliver, 2022).

There is recognition within institutions that learners from working-class and ethnic minority backgrounds face inequalities within compulsory education. However, the Social Mobility Commission (2016; 2024) consistently finds that inequality in the UK is increasing and opportunities to progress are limited for those born into working-class families. This stratification does not end when a person enrols at university. Despite decades of widening participation-based policies from the mid-1990s onwards and a shift in the composition of the student body, there remains an ingrained assumption among higher education institutions that students are a homogeneous group; white middle-class students remain central to the idea of a student, particularly within Russell Group universities (Reay et al, 2009; Friedman and Laurison, 2020). 'Other' students are often referred to as non-traditional or widening participation students, immediately setting them apart from their traditional peers.

Consequently, it is widely accepted that institutions are established, rooted in very conservative ideas of how things have always been, tried and tested, and reluctant to change (Brosnan and Turner, 2009; Bathmaker, 2019). The institutional habitus, more simply put, the culture, practices, and assumptions about students at universities, can affect the student experience and educators' attitudes and expectations toward students, leaving working-class students feeling like 'outsiders on the inside' (Reay, 2015:117). Where universities expect all students to have been prepared for the transition through schooling and familial connections, many students who need support beyond what has always been provided are overlooked (hooks, 2015).

The illusion of a 'classless environment' (Hanley, 2017:12) stems from the belief that merely being granted access to an elite space is sufficient to surmount the entrenched structural barriers within the English education system. These structural barriers exist within the university, and those who develop inclusion initiatives for working-class students often see only economic barriers, even though these interventions should be welcomed. They under-recognise the impact of social inequalities, including the habitus and psychosocial implications, as well as the additional emotional labour required of these students to meet the entry requirements for programmes such as Medicine (Reay, 2004; Reay, 2015; Friedman and Laurison, 2020).

For working-class medical students, habitus offers a valuable lens for understanding their unique challenges and experiences within the medical field. Although these students qualify through the necessary A-levels or through relevant access to medicine programs, they often enter university and medical training with lived experiences that are unfamiliar to traditional medical students (Reay, 2015; Hanley, 2019; Gilbert, 2018). According to Friedman and

Laurison's (2020) research, medical careers remain primarily accessible to those from professional backgrounds, with almost a quarter of new doctors having parents in medical fields. Consequently, the profession and its expectations are embedded in family life and individual habitus from an early age, fundamentally shaping individuals' belonging to the profession. Two-thirds of the remaining doctors come from senior professional occupations such as law. While these students do not have a history in medical professions, they are socialised into elite circles and belong to a group in which higher education is the norm (Friedman and Laurison, 2020; Gilbert, 2018). Bourdieu's concept of 'symbolic mastery' (Bourdieu, 1994: 156) explains this natural belonging through upbringing and socialisation into accepted forms of culture, language, and etiquette.

Paradoxically, working-class students are socialised to live in the world they belong to, a world where opportunities are limited, autonomy is scarce, and success is hard-won (Gilbert, 2018; Hanley, 2019). The risks that working-class students take when entering fields, compared to their middle-class peers, are often overlooked by higher education policymakers. The risk is that, rather than achieving a good degree, confidence, and a sense of entitlement, it is harder to attain.

Universities across all disciplines can be a complicated field to navigate for those who, throughout their lived experience, have not encountered the rules of engagement for elite institutions or an elite training programme. Similarly, the decision to widen participation to make university an option for students from all backgrounds has created complexity. As elite institutions and programmes such as medicine have consistently made attempts to be more inclusive, there remains a dearth of evidence to show that, indeed, rather than inclusion and opportunity for all, there are significant misunderstandings of what constitutes the modern student, particularly concerning social class (Friedman and Laurison, 2020; Social Mobility Commission, 2016; Reay, 2019).

Conversely, for working-class individuals aspiring to pursue a medical career, their cultural norms, language, and etiquette are often regarded as less 'legitimate or valuable than others' (Bathmaker, 2018: 23) within specific social spheres. The devaluation of working-class culture poses a problem, as research shows that traditional working-class values include a strong sense of community, resourcefulness in navigating life with limited resources, and a dedicated work ethic (Balmer et al, 2017). As a result, working-class medical students must rapidly adapt to both the unfamiliar university environment and the unspoken rules and new language. As Reay (2015) suggests, this process can damage individual identity, not only by unlearning what has been learned over a lifetime but also by effectively resetting their biography. Self-reflection and a new understanding that working-class norms and practices are 'not good enough' are necessary, and, for many, this leads to the realisation that people like them and their communities are judged as inferior (Reay, 2006; 2015).

Additionally, during their studies, they must also find a place to fit within the clinical environment and learn a further set of formal and informal expectations (Bathmaker, 2016; Hanley, 2016; Loveday, 2016). Research shows that the emotional labour and stressful working conditions required of doctors have a significant impact on wellbeing (Johnson et al., 2018; Looseley et al., 2019; Robinson et al., 2020). Understanding the impact of the additional labour required of working-class medical trainees through the lens of habitus

clarifies the emotional labour involved in transitioning from a working-class background to a middle-class profession.

In summary, Bourdieu's concept of habitus provides a valuable framework for understanding the deeply ingrained habits and dispositions that shape individuals' perceptions and reactions to the world. The challenges faced by working-class students in higher education are not merely financial but also deeply rooted in social inequalities that impact their confidence and well-being. Educational institutions must recognise and address these social inequalities to create more inclusive and supportive environments for all students. By understanding and addressing the impact of habitus, we can work towards a more equitable and inclusive educational system that truly offers opportunities for all.

Understanding Habitus and Class Boundary Crossing

Bourdieu's (1977) concept of habitus is crucial to his sociological theory, providing insight into how individuals navigate their social environments while being shaped by them. Habitus refers to the ingrained habits, skills, and dispositions acquired over a lifetime, primarily through a socialisation process that starts in childhood (Reay, 2015). Bourdieu describes habitus as a system of durable, transferable dispositions that shape thoughts, perceptions, and actions. Past experiences influence this framework, yet it remains flexible, allowing for ongoing adaptation (Bourdieu, 1977).

Habitus is formed through accumulated life experiences, starting in childhood, where family plays a critical role. Children internalise values and norms through interactions within their families, creating a foundational understanding of their social environment (Lareau, 2003). This foundation evolves through experiences with schools, peer groups, and workplaces (Bourdieu, 1977; Reay, 2015; Balmer et al., 2017), and these experiences remain with life transitions as part of the emerging habitus. Bourdieu emphasises that habitus is not static; ongoing experiences shape it. While it provides a framework for navigating the social world, it is also capable of change. An individual from a working-class background may adapt their dispositions to succeed in a new middle-class setting. However, the middle-class setting rarely needs to consider adapting its institutional habitus to support the success of all its students (Crew, 2024).

In a university setting, institutional habitus encapsulates how culture, norms, values, and practices shape the experiences of both staff and students (Reay et al, 2001). The dominance of middle-class cultures and practices can lead to internalised shame among working-class students. As Reay suggests, 'there is shame in both belonging and escape, shame in escape because it is about betrayal and desertion' (Reay, 2015, p. 115). These feelings reflect the need for change and for leaving behind the past, including family and friends, to fit into this newfound lifestyle. Therefore, the assumption that change is necessary can bring a sense of inferiority, which is not conducive to developing confidence or academic success (Reay, 2015; Skeggs and Loveday, 2015).

For instance, a working-class individual entering a middle-class profession may develop new attitudes and skills while still being shaped by their original habitus. However, when navigating traditionally middle-class spaces, working-class people can stand out for lacking what Bourdieu calls 'symbolic mastery' (1977:45). The way they speak, dress, and understand the space's norms can become readily apparent. In turn, this can cause a sense of being out of place, the belief that they must change to fit in, and even the belief that they

have succeeded by chance rather than through hard work (Friedman and Laurison, 2020). Many working-class people lack the self-assurance of the middle class due to their life experiences (Reay, 2015).

Reay (2015) further develops the concept of habitus by considering how the need to conform to social norms affects an individual's sense of self and can create identity conflicts. Arguably, navigating both the middle-class-dominated university setting and the middle-class-centred medical field, while trying to maintain personal trajectories and values, can negatively affect working-class students' sense of self. These variations in habitus affect attitudes and behaviours, influencing how individuals navigate social fields such as education, employment, and healthcare. Understanding the interplay between habitus, social structures, and individual experiences is crucial for comprehending broader social dynamics and mobility (Bourdieu, 1977; Balmer et al., 2017; Friedman and Laurison, 2020).

Socioeconomic background significantly affects habitus formation. Bourdieu argues that individuals from various social classes develop distinct habitus reflective of their conditions. For example, working-class individuals may experience economic hardship and limited access to cultural resources, leading to a habitus that emphasises immediate needs. The need to think in the short term can lead to debates about a lack of aspiration (Reay, 2006; Shildrick and Macdonald, 2016). In contrast, middle-class individuals often enjoy stability and greater access to educational opportunities, fostering a habitus characterised by a sense of agency and aspiration (Reay, 2019). It is this stability and confidence that support the belief of being deserving.

In addition to habitus, Bourdieu (1986) introduced the concepts of social and cultural capital to explain further how social inequalities are reproduced through education. These concepts are crucial for understanding the dynamics of educational attainment and the perpetuation of social stratification. Social capital refers to the networks of relationships and connections that individuals can draw upon for support and resources. In the context of education, social capital encompasses the relationships students have with their peers, teachers, family members, and community members. These networks can provide various forms of support, such as information about educational opportunities, emotional encouragement, and practical assistance (Bourdieu, 1986).

For example, a medical student with strong social capital might have parents who are well-connected within the educational system or, as Friedman and Laurison (2020) discuss, have parents who are practising doctors, providing them with valuable insights and advice on navigating university processes. This can lead to better employment outcomes, as students can utilise these connections to access resources and opportunities that may not be available to others (Reay, 2015). Cultural capital refers to the non-financial social assets that promote social mobility. These include education, intellect, speech style, dress, and even physical appearance. Institutions such as universities rely on the ability to network and navigate professional expectations as a pathway to success. Bourdieu identified three forms of cultural capital: embodied, objectified, and institutionalised (Bourdieu, 1986). Embodied cultural capital includes the knowledge, skills, and dispositions that individuals acquire through socialisation. For example, a student who has been exposed to a rich cultural environment from a young age may have a greater appreciation for literature, art, and music, which can enhance their educational experience. Institutionalised cultural capital includes

academic qualifications and credentials recognised and valued by society (Friedman and Laurison, 2020).

The interplay between social and cultural capital is critical in understanding educational inequalities. Students who possess high levels of both forms of capital are better equipped to navigate the educational system and achieve academic success. They can draw on their social networks for support and leverage their cultural knowledge and skills to excel in their studies (Bathmaker, 2018; Gilbert, 2018). Conversely, students from working-class backgrounds may lack access to accepted forms of both social and cultural capital, making it more challenging for them to succeed in the educational system. Limited access to correct networks of support or cultural resources leads to disparities in educational attainment and perpetuates social inequalities (Reay, 2004; Friedman and Laurison, 2020).

This theoretical framework provides a valuable lens for examining the experiences of working-class medical students, with a particular focus on the working-class habitus. Rather than viewing this habitus as something to be discarded, it should be recognised and maintained as a complementary asset in their transition to patient care. This perspective emphasises the importance of integrating their unique backgrounds and dispositions into their professional practice, enriching their interactions with patients and enhancing the quality of care they provide.

Extensive sociological research has investigated the frequency and extent of social mobility; however, there is limited understanding of its impact on individual identity, habitus, and preferences (Paulson, 2018). Individuals from working-class backgrounds who seek to enter the medical profession are making a significant effort to integrate into a field long associated with the middle class. Research by Friedman and Laurison (2020) suggests that approximately 5% of doctors originate from families with traditional working-class occupations. This figure is an improvement on the Social Mobility Commission report of 2016, which found that just 4% of doctors originated from working-class backgrounds (Social Mobility Commission, 2016). With almost 40% of the population claiming to be working class, clearly, medicine is far from representative of the communities it serves. Class distinction remains heavily discussed in terms of economic capital, and there is evidence that financial hardship is a factor in limiting opportunities, but class inequalities cannot be understood in simple economic terms (Reay, 2019; Friedman & Laurison, 2020).

Academics such as Hanley (2017) and Reay (2017) argue that the term ‘working class’ is infrequently used as a self-identifier. Marginalised communities more commonly employ terms such as ‘people like us’ (Ball, Davies et al., 2002:66) or refer to the area in which they grew up. These expressions result from the internalisation of a class-bound education system, class-segregated housing, and a media and cultural landscape that have persistently reinforced class prejudices (Hanley, 2017:12). However, the current debate around working-class identity centres on working people and those who sell their labour. This position attracts many people who have had access to privilege in their upbringing and educational opportunities; for example, many doctors sell their labour to the NHS, and academics sell their labour in the higher education sector (Friedman and Laurison, 2020). This approach to defining class overlooks the emerging habitus and the struggles of achieving educational success without the natural resources of those with familial historical success. However, the fashionable appeal of identifying as working-class can reduce some of the stigma associated with a typically judged identity. The complexities remain, leaving

those who have remained in working-class roles potentially viewed as not trying hard enough (Dersiewicz, 2014).

Research with working-class individuals (Loveday and Skeggs, 2012; Reay, 2015, 2017) reveals the pervasive risk and uncertainty in their lives. Participants emphasised that it is not merely financial insecurity, but also the constant struggle to maintain a facade of normalcy, while worry, guilt, and shame shape their experiences (Loveday and Skeggs, 2012, p. 482). This contradicts the notion of meritocracy in 21st-century Britain, which is described as a society where 'birth, not worth, dictates' (GOV.UK, 2012:2). Factors such as birthplace, family educational history, and intersectional identity continue to determine educational and professional success. To conclude, those who have a lived experience of class inequality and, through the risk and uncertainty, have accessed medical training against the odds, do so with much uncertainty about what to expect. The following section will discuss the experiences of those who have crossed boundaries from a working-class upbringing to embark on what remains the most elite of professions.

Medical Education – A Historic View

Medical education has long been a cornerstone of professional identity and social status in modern societies. Its evolution reflects broader shifts in social structures, ideologies, and institutional practices. This chapter examines the historical evolution of medical education in the United Kingdom, tracing its transformation from an unregulated craft to a highly structured and esteemed profession. It examines how sociological theories, particularly trait theory and Bourdieu's concepts of capital, habitus, and field, help illuminate the mechanisms through which medicine has maintained its elite status and resisted structural change (Carrigan and Pinchen, 2009; Bourdieu, 1984; Bourdieu and Wacquant, 2013).

In terms of professionalisation trait theory, as articulated by Carrigan and Pinchen (2009, in Brosnan and Turner, 2009), the defining features of a profession are identified as specialised knowledge, formal training, ethical standards, and a commitment to public service. These traits have historically justified the elevated status of medical professionals and their autonomy within society (Abbott, 2014). However, this model often obscures the social and cultural mechanisms that restrict access to the profession, particularly for individuals from working-class or marginalised backgrounds (Friedman and Laurison, 2019; Reay, 2017).

Bourdieu's theoretical framework offers a powerful lens for understanding how medical education reproduces social inequalities. Concepts such as cultural capital, symbolic power, and habitus reveal how students from privileged backgrounds are more likely to possess the dispositions and resources valued by elite institutions (Bourdieu, 1984; Reay, 1998; Balmer et al, 2017). These dynamics are further reinforced by institutional habitus and the hidden curriculum, which shape students' experiences and trajectories in subtle but profound ways (Hafferty, 1988; Michalec, 2011; Byrom and Lightfoot, 2012).

The chapter is structured to provide a chronological and thematic analysis. It begins with the pre-professional era and the pivotal Medical Act of 1858, which laid the groundwork for formal regulation. It then explores the rise of medicine as a 'definitive' profession through the lens of trait theory, followed by an examination of the socialisation processes that shape medical students' identities. The chapter also addresses the persistent elitism in medical admissions, the contradictions in widening participation policies, and the cultural conflicts

experienced by working-class students. Finally, it considers contemporary challenges and the future of medical education in a neoliberal context (Livesey, 2019; Sointu, 2019).

Together, these themes provide a foundation for the chapter's critical exploration of how medical education has evolved as both a professional and cultural institution, shaped by historical developments and contemporary inequalities. Drawing on a wide range of empirical studies and theoretical insights, this chapter aims to provide a critical understanding of how medical education has evolved historically and how it continues to perpetuate social inequalities despite reform efforts. It also highlights the importance of reflexivity and structural change in creating a more inclusive and socially just medical profession (Cribb and Bignold, 1999; O'Shea and May, 2017).

Pre-Professional Medicine and the Medical Act of 1858

Before the mid-nineteenth century, medical practice in the United Kingdom was unregulated and fragmented. Aspiring practitioners can enter the field through various routes, including apprenticeships, private instruction, or affiliation with one of the Royal Colleges. However, many individuals practised medicine without formal qualifications, relying instead on their ability to attract and retain patients. Oversight was minimal, and there was little consistency in training or standards (Boursicot and Roberts, 2009).

This lack of regulation created a profession that was internally divided and externally vulnerable. As Boursicot and Roberts (2009) note, 'the UK adopted a model in which regulatory authority was delegated to the professions themselves', a model that would come to define the British approach to professional governance. The pivotal moment in this transformation was the passage of the Medical Act of 1858, which established the General Council for Medical Education and Registration, later known as the General Medical Council (GMC). This body was tasked with overseeing medical licensing and education, effectively bringing disparate licensing bodies under a single regulatory framework.

The creation of the GMC was not without controversy. Appointments to the Council were predominantly controlled by the state, universities, and established medical institutions, effectively limiting the influence of ordinary practitioners and reinforcing existing hierarchies within the profession. This top-down structure reflected broader tensions between democratic representation and elite control within the profession. Despite these concerns, the Act marked a significant step in the professionalisation of medicine, transforming it from a collection of trades into a unified and regulated field (Caragh, Brosnan and Turner, 2004).

The Medical Act also laid the foundation for medicine's claim to social authority. By formalising entry requirements and centralising oversight, it legitimised the profession's demand for autonomy and material rewards in exchange for public service. This aligns with Abbott's (2014) argument that professions secure their status by controlling access to specialised knowledge and by establishing authority over domains of work.

However, the Act also reinforced exclusivity. As Caragh, Brosnan and Turner (2004) argue, the legislation 'consolidated the protective interests of various sub-groups,' effectively safeguarding the privileges of elite practitioners. This consolidation of power helped to entrench medicine's status as a 'definitive' profession, characterised by high barriers to entry and a strong internal hierarchy.

The legacy of the 1858 Act continues to shape medical education today. While universities now deliver training within the framework of higher education legislation, the GMC retains significant authority over curriculum design, learning outcomes, and professional standards (General Medical Council, 2023). The enduring narrative of ‘doctor knows best’ reflects the historical roots of medical authority and the profession’s resistance to external scrutiny.

Evidently, the Medical Act of 1858 was a foundational moment in the history of British medical education. It marked the beginning of a shift from informal, fragmented training to a centralised and standardised system. While it brought much-needed regulation and legitimacy, it also entrenched elitism and exclusion, dynamics that continue to influence the profession today.

Trait Theory and the Rise of the Medical Profession

The emergence of medicine as a recognised profession is closely tied to the development of trait theory within the sociology of professions. This theoretical framework identifies a set of defining characteristics that distinguish professions from other forms of work. These include specialised knowledge, formal training, ethical standards, and a commitment to public service (Carrigan and Pinchen, 2009, in Brosnan and Turner, 2009). These traits are not merely descriptive; they serve to legitimise the elevated status and autonomy of professional groups within society (Abbott, 2014).

Medicine is often cited as a definitive example of a profession that embodies these traits. These features, collectively referred to as 'trait theory', are frequently invoked to justify the privileged position of the medical profession. The ability of doctors to self-regulate and define their own standards further reinforces this authority (Abbott, 2014; Jenkins et al, 2021).

This professional status is not achieved overnight. Professions maintain their dominance by securing authority over specific domains of work and by monopolising the production and certification of expert knowledge (Abbott, 2014). In medicine, this is reflected in a highly structured and prolonged educational trajectory. The transformation from layperson to doctor typically spans several years, beginning with a 5–6-year undergraduate degree, followed by a 2-year Foundation Programme, and then speciality training that can take an additional 3–8 years (Jenkins et al, 2021). This extended process not only ensures technical competence but also acts as a gatekeeping mechanism, limiting access to those with the necessary cultural, economic, and social capital (Bourdieu, 1984; Bourdieu and Wacquant, 2013).

Becker’s ethnographic study*, Boys in White (1977),* provides a vivid account of this transformation. He observed that ‘Among the most desired and admired statuses is to be a member of a profession,’ and that such status is achieved ‘not through brief rites of passage but through prolonged instruction and supervised practice’ (Becker, 1977: 4). This process of professional socialisation is not merely academic; it involves the internalisation of norms, values, and behaviours that define what it means to be a doctor (Hafferty, 1988; Michalec, 2011).

From a Bourdieusian perspective, this transformation can be understood as the accumulation of cultural and symbolic capital. Medical students must learn to navigate the field’s expectations, often adapting their habitus to align with institutional norms (Bourdieu, 1984; Balmer et al., 2017). This process can be particularly challenging for those from working-class or non-traditional backgrounds, who may lack the cultural familiarity and social resources often taken for granted within elite institutions (Reay, 1998; Krstić et al., 2021).

Importantly, the professionalisation of medicine is neither neutral nor purely meritocratic. It is shaped by historical legacies and institutional structures that often reproduce social inequalities. The ideal of the 'meritocratic' doctor frequently conceals the advantages conferred by familial legacy and social networks (Sennett and Cobb, 1972; Friedman and Laurison, 2019). These forms of inherited capital facilitate entry into and success within the profession, perpetuating a cycle of privilege (Friedman et al., 2021).

In conclusion, while trait theory offers a valuable lens for understanding the formal attributes of professionalisation in medicine, it must be situated within a broader sociological context. The traits that define the profession are embedded within a field of power relations that privilege certain forms of capital and habitus over others. The rise of the medical profession, therefore, is not only a story of technical and ethical advancement but also one of social closure and exclusion (Bourdieu, 1990; Reay, 2017).

The Socialisation of Medical Students

The process of becoming a doctor extends far beyond the acquisition of technical knowledge and clinical skills. It involves a profound transformation of identity, values, and behaviour—a process sociologists refer to as professional socialisation. This transformation is central to the reproduction of the medical profession and is shaped by both formal education and informal, often hidden, cultural norms.

Becker's classic ethnography, Boys in White (1977), remains a foundational text in understanding this process. He observed that 'Among the most desired and admired statuses is to be a member of a profession,' and that such status is achieved 'not through brief rites of passage but through prolonged instruction and supervised practice' (Becker, 1977: 4). This prolonged immersion into the medical field is not only about learning to diagnose and treat but also about internalising the values, language, and expectations of the profession.

This internalisation is often facilitated through what Hafferty (1988) termed the hidden curriculum, the implicit lessons, values, and norms that are conveyed through institutional culture, peer interactions, and role modelling. While the formal curriculum teaches anatomy, pharmacology, and clinical procedures, the hidden curriculum teaches students how to behave, whom to emulate, and what it means to be a 'real' doctor (Michalec, 2011; Lawrence et al, 2018). These lessons are powerful precisely because they are unspoken and often go unchallenged.

The socialisation of medical students can be understood as a process of acquiring and deploying various forms of capital, particularly cultural and symbolic capital, within the field of medicine (Bourdieu, 1984; Bourdieu and Wacquant, 2013). Students must learn to navigate the field's expectations, often adapting their habitus to align with institutional norms. This adaptation is not equally accessible to all. Those from privileged backgrounds often arrive with a habitus already attuned to the field, while others must undergo a more difficult and sometimes painful process of transformation (Reay, 1998; Balmer et al, 2017).

This process can be especially challenging for students from working-class or non-traditional backgrounds. As Krstić et al. (2021) note, these students often face multiple transitions, moving from home to university, from classroom to clinic, each requiring them to learn and take part in a process without a rulebook or support to understand expectations. The emotional labour involved in this adaptation is significant and often under-recognised.

Feelings of alienation and self-doubt are common, particularly when students perceive a mismatch between their identity and the profession's dominant norms (Addison et al., 2022; Loveday, 2015).

Moreover, the socialisation process is not only about conformity but also about exclusion. The hidden curriculum can reinforce existing hierarchies and marginalise those who do not fit the traditional mould of the medical professional. As Sointu (2017) argues, clinical learning environments often entrench inequality by privileging certain ways of being and knowing while devaluing others. This symbolic violence (Bourdieu, 1990) can have lasting effects on students' confidence, well-being, and career trajectories.

The socialisation of medical students is a complex and deeply sociocultural process. It involves more than learning medicine; it is about becoming a doctor in a way that aligns with the profession's historical and institutional expectations. Understanding this process is essential to addressing the subtle yet powerful mechanisms by which inequality is reproduced in medical education.

Access, Elitism, and the Construction of the 'Good Doctor'

Despite the formalisation and expansion of medical education, access to the profession remains deeply unequal. The admissions process continues to reflect entrenched class hierarchies, privileging those with the cultural, social, and economic capital to navigate its demands. While medicine is often portrayed as a meritocratic field, structural barriers persist, disproportionately affecting applicants from lower socio-economic backgrounds (Friedman and Laurison, 2020; Dorling, 2014).

One of the most significant gatekeeping mechanisms is the University Clinical Aptitude Test (UCAT). Although designed to assess cognitive ability and professional aptitude, the UCAT has been shown to favour students from independent and grammar schools, who are more likely to have been coached or to have encountered similar testing environments (Latham et al., 2025). Even among students predicted to achieve top A-level grades, those from less advantaged backgrounds consistently score lower on the UCAT, suggesting that the test may reinforce rather than mitigate educational inequality.

Beyond academic performance and aptitude testing, applicants are often expected to demonstrate extracurricular achievements, work experience, and polished interview skills, criteria that are more accessible to those with supportive networks and financial resources (Friedman and Laurison, 2020). As Dorling (2014) argues, inequality in Britain is not simply a matter of income but of opportunity, and professions such as medicine are key sites where privilege is reproduced.

The interview stage is often framed as the final, decisive step in selecting candidates who not only demonstrate academic excellence but also possess the personal qualities deemed essential for the medical profession. Typically conducted in either one-to-one or multiple mini-interview (MMI) formats, interviews are intended to assess communication skills, ethical reasoning, empathy, and motivation for medicine (Latham et al., 2025). However, these assessments are far from neutral. As Razack et al. (2018: 27) argue, the interview process is shaped by implicit assumptions about what constitutes a 'suitable' candidate. These assumptions often reflect dominant cultural norms and institutional expectations, privileging those who are confident, articulate, and familiar with the professional discourse of medicine. In practice, this means that candidates from middle- and upper-class backgrounds, who are

more likely to have been socialised into these norms, are better positioned to succeed in the admissions process.

The construction of the ‘good doctor’ is thus not only about clinical competence or ethical integrity but also about cultural fit. As Latham et al. (2025) note, interview panels often unconsciously favour candidates who mirror their own educational and social trajectories. This creates a feedback loop in which the profession reproduces itself in its own image, reinforcing existing hierarchies and excluding those who do not conform to the traditional mould. Moreover, the notion of ‘excellence’ in interviews is often narrowly defined. Attributes such as resilience, emotional intelligence, and lived experience, which may be more prevalent among applicants from working-class backgrounds, are frequently undervalued or overlooked. This narrow construction of merit can lead to the systematic exclusion of candidates who might bring valuable perspectives and skills to the profession (Friedman and Laurison, 2020; Dorling, 2014).

The concept of institutional habitus (Reay, 1998; Byrom and Lightfoot, 2012) is particularly useful for understanding how medical schools implicitly favour middle-class norms and behaviours. Interviews and personal statements often reward confidence, fluency in professional discourse, and familiarity with the healthcare system, qualities more commonly found among applicants from privileged backgrounds. For working-class students, the process can feel alienating and exclusionary, described as ‘like visiting a foreign land with its own language and behaviours’ (O’Shea et al., 2017: 208). Arguably, it is unsurprising that working-class people opt out of these elite careers, as they are disadvantaged from the outset.

The interview process imposes a significant emotional burden on applicants from underrepresented groups. Candidates must not only perform well but also decode and adapt to unfamiliar cultural expectations. This can foster self-doubt, particularly when success is perceived as contingent on suppressing aspects of one’s identity (Addison et al., 2022; Loveday, 2015). Despite these challenges, research shows that students from non-selective state schools and mature applicants often outperform their privately educated peers by the end of medical training (Kumwenda et al., 2017). These findings challenge deficit narratives and highlight the resilience and capability of students from less advantaged backgrounds. The obstacles many of these students must overcome to succeed highlight the structural inequalities embedded in the admissions process. As Dorling (2017) notes, austerity policies and market-driven reforms have exacerbated educational inequalities, making it harder for disadvantaged students to access elite professions. In this context, the rhetoric of meritocracy can obscure how privilege is maintained. Latham et al. (2025) argue that unless medical schools actively address the social and structural barriers to entry, efforts to widen participation will remain superficial. Steps such as diversifying interview panels and incorporating contextual admissions criteria are a step in the right direction. However, as Razack et al. (2018: 51) caution, these measures must go beyond tokenism. True inclusivity requires a re-evaluation of the values and assumptions underpinning selection processes. This includes recognising that excellence takes many forms and that a more representative medical workforce is not only fairer but also better equipped to serve a diverse population.

In conclusion, the medical admissions process, particularly the interview stage, plays a crucial role in shaping who becomes a doctor and which kinds of doctors are valued. Without

critical reflection and structural reform, the process risks perpetuating a narrow and exclusionary vision of the medical profession.

Widening Participation and Policy Contradictions

The 1990s marked a pivotal shift in UK higher education policy, with a strong government push towards widening participation (WP). The core intentions behind WP policies in higher education are grounded in principles of equity, efficiency, and mobility. At their foundation is a commitment to social justice, aiming to dismantle entrenched barriers that have historically excluded marginalised groups from accessing higher education (Reay, 2017; O'Sullivan, 2023; Gorard and Smith, 2006). WP also serves an economic imperative, seeking to utilise the full breadth of talent across society to meet workforce demands, particularly in critical sectors such as healthcare and medicine (British Medical Association, 2024; Coyle et al., 2021). Additionally, WP is framed as a mechanism for social mobility, enabling individuals from disadvantaged backgrounds to improve their socioeconomic status through educational attainment (Bathmaker et al., 2018; Milburn, 2012; Friedman and Laurison, 2020).

However, critics argue that WP initiatives often devolve into a 'numbers game', where success is measured by the number of students from underrepresented backgrounds entering higher education, rather than by the quality of their experiences or outcomes (Baxter et al., 2015; Krstić et al., 2021; O'Sullivan, 2023). This approach risks tokenistic inclusion, in which institutions focus on meeting diversity quotas without addressing the deeper cultural, structural, and pedagogical barriers that shape student trajectories. For example, working-class students may be admitted yet still face alienation, imposter syndrome, and a lack of belonging within elite academic environments (Addison and Mountford, 2014; Reay et al., 2009; Loveday, 2015). Moreover, the emphasis on enrolment figures can obscure persistent inequalities in retention, progression, and access to prestigious professions such as medicine, where symbolic and cultural capital continue to play a decisive role (Bourdieu, 1986; Ball et al., 2002; Balmer et al., 2017). The intention was to democratise access to higher education, particularly for underrepresented groups, including those from lower socioeconomic backgrounds.

However, while participation rates have increased, particularly among working-class and minority students (DfE, 2024; Boeren and James, 2017), access to elite professions such as medicine remains disproportionately skewed. Despite policy interventions, medicine continues to be dominated by students from affluent, often privately educated backgrounds (Boursicot and Roberts, 2009; Latham et al, 2025). This literature review demonstrates that while progress has been made in diversifying the doctor workforce, the medical field continues to fall short of being representative of the communities it serves. Many young people strive to excel within a stratified education system. Nevertheless, the policy focus remains fixed on the meritocratic ideal that equates hard work with success, even as the persistent underrepresentation of the working class in medicine reveals the limitations of this narrative (Reay, 2017; Friedman and Laurison, 2020).

Notably, efforts to make medical education more inclusive have gained traction in recent decades. In the 1990s, a chance encounter between Professor Cyril Chandler, then Dean of Guy's Medical School, and a young boy sparked discussions about widening access to medicine. The boy, who expressed interest in becoming a doctor, was later discouraged by his teacher, who explained that none of the local schools could help him obtain the qualifications required for medical school (The Right Mix, 2015). This encounter led to the

development of an extended medical degree programme at King's College London, which offered fifty places annually to students from non-selective state schools. Admissions were based on individual circumstances rather than traditional academic routes. While competition for these places remains high, the process is widely regarded as fairer than standard applications because candidates come from similar educational and social backgrounds (The Right Mix, 2015).

This example illustrates both the promise and the complexity of widening participation in a field as hierarchical as medicine. While such initiatives represent meaningful steps toward inclusion, they also highlight the structural barriers that continue to shape access to the profession. The continued underrepresentation of working-class students in medicine suggests that more systemic change is needed—not only in admissions policies but in how institutions define merit, support diverse learners, and challenge the cultural norms that shape professional identity.

Cultural Conflict, Identity, and Belonging

For students from working-class backgrounds, entering medical education often involves navigating a profound cultural dislocation. The dominant culture of medicine, steeped in middle-class norms, professional decorum, and institutional prestige, can feel alienating and exclusionary. This dissonance is not merely academic; it is deeply personal, affecting students' sense of identity, belonging, and self-worth (Reay, 2017; Loveday, 2015).

The concept of institutional habitus (Reay, 1998; Byrom and Lightfoot, 2012) helps explain how elite institutions like medical schools reproduce social hierarchies. These institutions are not neutral; they are structured by histories of exclusion and shaped by assumptions about who belongs and what success looks like. For many working-class students, the experience of entering such spaces is described as 'like visiting a foreign land with its own language and behaviours' (O'Shea et al, 2017: 208). This metaphor captures the emotional and cultural labour required to decode and adapt to unfamiliar norms.

This resilience, however, does not erase the cultural dissonance many students encounter upon arrival; instead, it highlights the extent to which they have achieved their success despite systemic barriers. They have navigated a stratified and often under-resourced compulsory education system, frequently outperforming expectations in schools that may lack the cultural capital, academic resources, or institutional support typically associated with university preparation (Greenhalgh et al, 2004; Kumwenda et al, 2017). Their presence in medical school is not accidental; it is the result of sustained effort, aspiration, and the ability to overcome systemic disadvantage.

Despite these achievements, the transition into medical education can still be jarring. Students may experience what Bourdieu (1990) terms a cleft habitus, a disjuncture between their embodied dispositions and the expectations of the field. They may feel pressure to suppress aspects of their identity to conform to institutional norms, leading to feelings of belonging, shame, and emotional exhaustion (Addison et al, 2022). These experiences are compounded by the underrepresentation of working-class staff and role models in medical faculties, which reinforces the perception that success requires assimilation.

The dominant culture of medical education often fails to recognise the value of the experiences and knowledge that working-class students bring. As Skeggs and Loveday (2012: 473) argue, the historical legacies of distinction continue to symbolically mark these

students as ‘bearers of bad culture, faulty psychology, as potentially dangerous, degenerate, and undeserving'. This symbolic violence (Bourdieu, 1990) is enacted through subtle cues, such as expectations around dress, speech, and behaviour, that signal who is seen as a legitimate future doctor. The hidden curriculum further reinforces these exclusions. While the formal curriculum teaches clinical knowledge and technical skills, the hidden curriculum transmits unspoken norms about professionalism, hierarchy, and emotional detachment (Hafferty, 1988; Michalec, 2011). Students who do not intuitively grasp these norms may be perceived as less competent or committed, even when their academic performance is strong.

To foster genuine belonging, institutions must move beyond tokenistic inclusion and engage in structural transformation. This includes diversifying faculty, embedding inclusive pedagogies, and re-evaluating what constitutes professionalism and excellence (Coyle et al, 2021; Reay, Crozier and Clayton, 2009). As Razack et al. (2018) argue, a more representative medical workforce is not only fairer but also better equipped to serve a diverse population.

Evidently, the cultural conflict experienced by working-class students in medical education is both real and consequential. However, these students have already demonstrated their capability by overcoming significant barriers in compulsory education. Recognising and valuing their resilience, insight, and lived experience is essential for creating a medical education system that is not only inclusive but transformative.

This literature review has critically examined the historical, sociological, and institutional dimensions of medical education in the UK, revealing how the profession has evolved through mechanisms of regulation, professionalisation, and cultural reproduction. While the formalisation of medical training has brought legitimacy and standardisation, it has also entrenched elitism and exclusion, particularly through admissions practices and the hidden curriculum. Drawing on trait theory and Bourdieu’s concepts of capital, habitus, and field, the chapter has shown that access to medicine is not simply a matter of merit or aptitude, but is deeply shaped by social class, cultural familiarity, and institutional norms.

Despite policy efforts to widen participation, the medical profession remains disproportionately populated by students from privileged backgrounds. The persistence of structural barriers, such as biased admissions criteria, cultural gatekeeping, and symbolic violence, undermines the meritocratic ideals that underpin widening participation rhetoric. Initiatives aimed at inclusion often fall short by focusing on increasing enrolment rather than transforming the institutional cultures that marginalise non-traditional students—as such, widening participation risks becoming a superficial numbers game unless accompanied by deeper structural reform.

The review also highlights the emotional and cultural labour required of working-class students to navigate elite medical environments. Their experiences of misrecognition and cultural dissonance underscore the need for a more reflexive and inclusive approach to medical education—one that values diverse forms of capital and redefines what it means to be a ‘good doctor'. Ultimately, achieving equity in medical education requires not only opening the gates but also reshaping the terrain within. This calls for a reimagining of professionalism, pedagogy, and institutional habitus to ensure that the future of medicine reflects the diversity and complexity of the society it serves.

Loss of security – navigating industrial action. Trainee doctors – Learning in crisis

The incoming government in 2010 employed its neoliberal ideological stance to reduce the size of the state and cut back on state-provided welfare. Faced with increasing public debt and rising unemployment, the coalition government of Conservatives and Liberal Democrats, led by Prime Minister David Cameron and Chancellor of the Exchequer George Osborne, proposed reducing government spending by an average of 20% over four years (Borges et al. 2013).

The British governments elected in 2010 and 2015 prioritised austerity as a central component of their policy agendas, aiming to revitalise the economy by reducing public spending. However, when comparing wage growth internationally between 2007 and 2018, it becomes evident that the UK underperformed, with a negative figure of-2% (Torjeson, 2013). Austerity, as explored by Livingston (2014), investigates the impact of ideas on economic policies and politics, arguing that the primary issue during the financial crisis, often perceived as profound, was rooted in ideas. These ideas were grounded in political ideology rather than in the improved health and welfare of its citizens (O'Hara, 2015; Alston, 2018).

Consequently, during the initial years of the coalition government's austerity policies, O'Hara's research uncovered a prevailing sense of 'fear' in the UK, primarily fueled by the Welfare Reform Act of 2012. This led to a surge in food bank usage, as Job Centre staff monitored claimants for detrimental effects on mental well-being (O'Hara, 2015; Bambra, 2019). The reduction in social safety nets heightened the demand for mental health services, often overshadowing the humane aspect of healthcare providers (Stuckler and Basu, 2013). UN Special Rapporteur Phillip Alston, following his 2018 UK tour, criticised the government's austerity policies, attributing unnecessary suffering to those living in poverty (Alston, 2018).

Although the NHS is often considered in isolation, it is a function of the wider welfare state, responding to the needs of society as a whole. At its inception in the post-war years, the welfare state was developed to tackle what Beveridge considered the 'Five Giants' (Timmins, 2018:8) of Want, Squalor, Ignorance, Idleness and Disease. The welfare state was created on the premise that if the state could support people to access good education, work, safe housing, a financial safety net at times of need and healthcare, free at the point of use, people would be enabled to live good lives and contribute to the economy (O'Hara. 2015; Timmins2018).

Under this understanding, when social safety nets loosen or are deliberately removed through policy choices, people become poorer, housing deteriorates, access to education becomes more difficult, and people get sicker, placing additional demands on services across the social system (Marmot, 2010; O'Hara, 2015; Bhambra, 2019). Austerity, as a deliberate political decision, weakened the social safety net from 2010 onwards and left all citizens more vulnerable. As the next section will show, political decisions do make a difference.

Patient Satisfaction within the NHS

The first two years of the New Labour Government in 1997 saw patient satisfaction with the NHS rise from 12% to 46%. Except for a slight decline in 2001, the NHS received its highest patient satisfaction rating of 70% from 2001 to 2010 (King's Fund, 2011). By 2021, the

National Social Attitude Survey showed that patient satisfaction had dropped to 36% (King's Fund, 2022). In response, the BMA said that the findings were unsurprising, as they were ‘a direct consequence of a service which has been pushed to the edge of collapse with severe deficits in staffing, in beds, in community services, in facilities, and in equipment’ (Waters, 2022: no pagination). The comparison is stark, and, when measured over a prolonged period, patient satisfaction can indeed reflect political approaches to health and welfare.

Between 1997 and 2010, New Labour sought to shift the NHS from a paternalistic model to one of patient choice and to expand many services to include the private sector. Private sector services were paid for by the NHS and remained free for patients to access. The NHS Plan (2000), introduced by the New Labour Government, committed to reducing waiting times to under three months, creating public health information initiatives, and increasing staff numbers. These reforms led to growing satisfaction with the NHS. However, they were not perfect, and many argue that during this period there was a greater shift towards a managerial system under new funding formulas (May 2013). Despite these critiques, the government of the day was intent on tackling health inequalities across the country.

Furthermore, the latest publication, ‘Health Equity in England: Revisiting the Marmot Review After 10 Years,’ underscored the severe impact of austerity on critical areas, including child poverty, education, housing, and access to a healthy lifestyle (Marmot, 2020). Despite advancements in clinical healthcare accessibility, the adverse effects of social determinants of health persist (Langthorne, 2019:76 in Bambra, 2019). In this context, it is crucial to consider health holistically, as defined by the World Health Organisation, encompassing physical, mental, and social well-being (WHO, 2023). Poverty serves as a catalyst for health inequality, as exemplified during the Great Depression of the 1930s, highlighting the correlation between increasing poverty and deteriorating health (Bhambra, 2019).

Following the formation of the coalition government in 2010, against the backdrop of a global recession, the UK's National Health Service (NHS) faced renewed scrutiny and a pressing need for reform. It was during this pivotal period that the Health and Social Care Act of 2012 was introduced, with the primary aim of enhancing patient care and addressing key issues within the healthcare system. The Marmot Report (2010) emphasised the pervasive nature of health disparities, particularly in relation to socioeconomic factors, which informed the policy discourse surrounding the Health and Social Care Act of 2012.

This acknowledgement of the Marmot Report within the context of the Health and Social Care Act of 2012 recognised the need for comprehensive, holistic approaches to healthcare policy and reform. It emphasised the importance of a more nuanced understanding of health disparities and the social and economic factors that underpin them. The Health and Social Care Act in England, enacted in March 2012, marked a significant turning point in the history of the National Health Service (Pollock, 2012; Pownell, 2013).

Since its establishment in 1948, the NHS has provided free, universal healthcare based on need, not the ability to pay. Critics argued that the reforms, including the introduction of competitive markets and private providers, could undermine the principle of equal access and potentially compromise free and universal public healthcare. Conversely, the government maintained that these reforms would improve efficiency and enhance patient experience (Speed and Gabe, 2013; Pownall, 2013). To support this, the ideology shifted towards devolving and fragmenting services across the private sector, thereby fostering

competition among service providers at the lowest cost (Pownall, 2013). During the drafting of this policy, the British Medical Association expressed significant concerns about increased managerialism and the reduction of medical autonomy within the Act. There were fears that this might lead to a shift away from patient choice and manageable workloads towards a decline in service availability (Pollock, 2012).

Similarly, the 2018 BMA report highlighted a decade of underfunding and increased work demands, fostering a culture of blame and fear among NHS doctors (BMA, 2018), a sentiment echoed in the 2013 Berwick report that emphasised poor working conditions and resource scarcity. These austerity measures were implemented across the health service. 'The defining premise of neoliberalism is minimal state interference, complemented by the decentralisation and dispersion of central power, and the promotion of private enterprise' (Pownall, 2013, p. 423). For doctors at the heart of the healthcare system, as the population becomes poorer, the demand for services increases. This, along with a depleted workforce and reduced services, creates significant challenges for doctors working and training within the healthcare system (BMA, 2023).

COVID-19 – Doctors working in a broken system.

In December 2019, information emerged from Wuhan, China, about a novel respiratory disease. Scientists grew increasingly concerned that the virus would spread worldwide (WHO, 2019). Meanwhile, the Conservative Party, led by Boris Johnson, had just secured a landslide majority in the UK Parliament on the promise that he would 'Get Brexit Done' (Conservative Party Manifesto, 2019: no pagination). This referred to the outcome of the 2015 referendum on the UK's departure from the European Union. Recent evidence from the UK Covid Inquiry shows that departments across the UK government and the Civil Service shifted their focus from normal duties to preparing for Brexit, a shift that persisted for much of the period from 2015 to 2020. Regrettably, this included pandemic preparedness.

The UK Covid Inquiry is chaired by Baroness Heather Hallett, a former Court of Appeal judge. The Inquiry's primary purpose is to comprehensively investigate and report on the COVID-19 pandemic preparations and response in England, Wales, Scotland, and Northern Ireland up to and including June 28, 2022. It aims to cover both reserved and devolved matters across the UK while avoiding duplication with other ongoing public inquiries. The Inquiry is examining the following: resilience and preparedness; core UK decision-making and political governance; the impact of the COVID-19 pandemic on healthcare systems in the four nations of the UK; and vaccines, therapeutics, and procurement (UK Covid Inquiry, 2023: no pagination). The Inquiry is committed to examining both reserved and devolved matters across the United Kingdom while minimising duplication with other public inquiries (Covid Inquiry 2023).

Since June 2023, the Inquiry has heard from leading politicians, civil servants, and experts across medicine, science, and the social sciences. In addition to submitting written evidence, these experts have appeared before the Inquiry to give oral evidence under legal examination. The first module explored the UK's preparedness to respond to a pandemic such as COVID-19. There were differences in understanding the impact of austerity on political decisions to reduce welfare spending since the 2010 election. Former Chancellor George Osbourne claimed at the hearing that budget cuts introduced during the period of

austerity had no impact on the country's ability to manage the pandemic (Covid Inquiry, 2023). The medical profession fundamentally disagrees.

For example, the BMA's chair of council, Phillip Banfield, a consultant obstetrician, said, 'I have seen at first hand the damage wrought by years of austerity and a failure to prioritise the nation's health.' Banfield added that 'the UK was severely on the back foot when Covid-19 took hold, and this proved disastrous for the doctors I represent and the millions who suffered at the hands of the virus'. Banfield's view is supported by further research into junior doctors' experiences during the pandemic. Previous chapters have shown that for junior doctors, stress, uncertainty and burnout are commonplace, even among those with 8 years' experience just before they become consultants.

However, the pandemic took this to extremes. Gordon et al. (2022) found that intense grief significantly affected doctors' well-being. With routine work cancelled and, in many cases, Covid patients the sole focus of doctors' work, ordinary practices disappeared. Doctors at the centre, trained to ensure that patients have dignity in care and at death, had to watch patients die without their loved ones. Some hospitals provided a video link for patients' families, and it was the doctors who made the call to relatives informing them of their loved ones' deaths. Spiers et al. (2021) found that junior doctors faced significant trauma. The patient death rate was unprecedented, and to cope, many doctors in the study reported dehumanising patients. As patients died and the ward emptied, it would quickly fill with more sick patients, leaving little time to process the grief.

During the pandemic, doctors at all levels saw a decline in educational opportunities, with many reporting that when they were away from the wards they were frantically trying to learn as much as possible about the disease and treatments in their spare time (Spiers et al. 2021; Gordon et al. 2022). Moreover, doctors knew they were at risk of contracting the virus. Within the first year of the pandemic, 20% of doctors had been infected with COVID-19 at least once, and tragically more than fifty had died. Thousands of doctors have suffered long-term effects of the virus (BMA, 2022). The BMA's 2022 report, 'The Impact of the Pandemic on the Medical Profession', highlights how an unprepared system of resources and governance left the profession trying to fulfil their medical duty to treat patients in an unsafe system. In addition to the impact of austerity, which had reduced resources across the NHS, the lack of pandemic preparedness left medical staff at further risk.

One example of this was the lack of Personal Protective Equipment (PPE) for those treating COVID-19 patients. This prompted the government to panic-buy and award large numbers of contracts to people and companies that had not previously supplied or manufactured PPE. NHS procurement was simplified under the Health and Social Care Act 2012, which extended the supply chain to anyone with the means to supply (Pollock, 2012; Pownall, 2013). According to the Public Accounts Committee (2023), this period of panic buying was disgraceful and failed to ensure the protection of medical staff. Of all the PPE contracts awarded, 24% are now under dispute. These disputes involve contracts for products that were unsuitable for their intended purpose. The Department for Health and Social Care (DHSC) incurred a significant loss during the first year of the pandemic. They spent £12 billion on personal protective equipment (PPE), but 75% of that spending went to inflated prices and PPE that did not meet the necessary standards. This included a staggering £4 billion worth of PPE that could not be used in the NHS and had to be disposed of. Since

reviews into the pandemic have begun, evidence continues to emerge about the inequalities within the health service (BMA, 2023).

According to a 2021 study at the University of Southampton, even when PPE was available, it was designed to standard size and feature specifications for white males. This means that for healthcare workers who are female or from a Black or Minority Ethnic background, the masks do not fit the shape of their faces. In the case of a transmissible virus such as COVID-19, these professionals remain exposed to the virus. Given the evidence that ‘during the first wave, Black African people were 3.7 times more likely to die than white men’ (BMA, 2022:9), it is unsurprising that doctors and other healthcare workers did not feel protected by the UK government.

Consequently, doctors have emerged from the pandemic with significantly higher levels of stress and dissatisfaction with their profession, having witnessed patients and colleagues become ill or die. As Prudenzi (2020) suggests, working in consistently stressful situations can have a detrimental impact on individual health and well-being. Poor mental well-being, stress and anxiety can lead doctors to burn out, become physically ill, and even experience suicidal ideation. The focus on COVID-19 and the lack of access to healthcare during this period have created backlogs across the health system. In short, the population who were already sicker due to increasing inequalities exacerbated by austerity are sicker still since the pandemic first hit, putting further pressure on the health system and therefore on doctors (Marmot, 2010; BMA, 2023). Admission to wards is currently taking over 24 hours, with sick patients sitting in chairs covered with blankets due to a lack of beds (Sky News, 2023: no pagination).

To regain some of this respect, in September 2024, the term 'junior doctor' was replaced with ‘resident doctor’; this change was widely agreed upon by the medical profession and accepted by the current government. The change recognises that doctors spend up to 10 years specialising in becoming consultants and are fully qualified; the term 'junior' is considered to diminish the expertise of these professionals. In addition to doctors being failed professionally, the rising cost of living in the UK and the NHS's resource shortages have led to horrendous working conditions and a real-terms pay cut of 26% for junior doctors since 2008 (Endicott, 2023). Prime Minister Rishi Sunak has denied a crisis in the NHS, insisting that backlogs are unavoidable due to the 2020 pandemic. Responses from the BMA and senior clinicians have called Sunak's views ‘delusional’ and ‘disingenuous’ (Campbell and Walker, 2023: no pagination).

The lack of government support and planning, the failure to treat doctors as respected professionals, and austerity, pay concerns, and working conditions have together led to the de-professionalisation of medicine. Pay disparities among junior doctors in the UK remain central to the broader debate about the sustainability and fairness of the NHS workforce. Over the past decade, junior doctors have experienced a significant erosion of their real-terms income. According to the British Medical Association (BMA), between 2008 and 2022, their pay declined by approximately 26% when adjusted for inflation (BMA, 2024: no pagination). This reduction was not the result of explicit wage cuts but of stagnant salaries amid rising living costs, including housing, transport, and energy. Consequently, junior doctors have seen their living standards decline year after year, even as they work longer hours and face increasingly demanding workloads (BMA, 2024).

This prolonged erosion of real-term pay prompted a series of industrial actions beginning in 2022, with junior doctors staging multiple strikes to demand fair compensation and improved working conditions. The most notable was the six-day strike in January 2024—the longest in NHS history. While pay was a central issue, these strikes also reflected broader dissatisfaction with the systemic undervaluation of medical professionals and the cumulative effects of austerity. In response, the government and the BMA reached an agreement in mid-2024, granting an average pay rise of over 20% over two years. However, the BMA emphasised that junior doctors remained more than 20% behind their 2008 pay levels in real terms (BMA, 2024).

Beyond headline figures, structural inequities continue to shape the lived experiences of junior doctors. Many routinely work unpaid overtime beyond their contracted hours, often without recognition or compensation. This practice undermines morale and fosters a sense of professional exploitation. The rotational nature of medical training, which requires frequent relocations between hospitals, adds further instability, disrupting personal lives, hindering continuity of care, and complicating efforts to establish support networks or secure stable housing (BMA, 2024).

These challenges are not evenly distributed. Junior doctors from working-class backgrounds face disproportionate difficulties, as they are less likely to have access to financial support or family-provided accommodation. The practical and financial strain of securing temporary housing for each rotation is particularly acute for them. This reflects broader patterns of inequality within the profession, where access to resources and social capital significantly shape one's ability to navigate the demands of medical training. The result is a heightened sense of insecurity and dissatisfaction, especially among early-career doctors still establishing their place within the medical hierarchy (BMJ, 2024).

However, the challenges facing junior doctors are not solely economic. Bloom's (2002) concept of de-professionalisation offers a valuable lens for understanding the structural and cultural shifts within medicine. Historically defined by autonomy, authority, and public trust, the profession has increasingly been subjected to bureaucratic control and market-driven reforms. For junior doctors, this is evident in the erosion of control over working conditions, heightened managerial oversight, and the erosion of traditional career pathways. The symbolic rebranding of junior doctors as 'resident doctors' in 2024 was intended to affirm their professional status (BMA, 2025). However, without substantive changes to pay structures, working conditions, and institutional culture, such gestures risk being perceived as superficial, echoing Bloom's (2002) warning that symbolic recognition cannot substitute for genuine professional autonomy and respect.

Bourdieu's (1991) concept of symbolic violence complements Bloom's theory of professionalisation by showing how such dynamics are internalised and legitimised through cultural norms and institutional practices. Among junior doctors, symbolic violence is evident in the normalisation of long hours, unpaid overtime, and frequent relocations as necessary rites of passage (Friedman and Laurison, 2020). These expectations are presented as professional norms, yet they obscure structural exploitation and discourage resistance. For working-class doctors, the lack of financial support and social capital intensifies these pressures, even though their struggles are often misinterpreted as individual shortcomings rather than systemic inequities (Greenhalgh, 2015).

This internalisation of professional insecurity exemplifies symbolic violence. Many junior doctors report burnout, inadequacy, and alienation, particularly in the aftermath of the COVID-19 pandemic. Despite their critical role during the crisis, they received little long-term recognition or reward. The perceived lack of appreciation from both the government and the public has left many feelings disconnected from a profession they once regarded as a calling. This erosion of professional identity is not only a hallmark of deprofessionalisation but also a form of symbolic violence, in which the dominated come to accept their marginalisation as natural or deserved (Jagger, 2025).

Despite medicine's traditional image as a secure and prestigious career, employment for doctors in the UK, particularly junior doctors and early-career general practitioners, has become increasingly precarious. This precarity is characterised by job insecurity, underemployment, and a lack of clear progression pathways, all of which are exacerbated by systemic failures in workforce planning. According to the BMA, many newly qualified GPs struggle to find sufficient work, with some unable to secure regular sessions or salaried roles despite the ongoing crisis in primary care (BMA, 2025). This mismatch between workforce supply and demand reflects a failure to align medical training outputs with available employment opportunities.

The situation is equally troubling for junior doctors. Despite the NHS continuing to face chronic staffing shortages, many report difficulty securing specialty training posts or stable employment after completing their foundation years. In 2024, a growing number of medical graduates were placed on 'placeholder' lists because of a lack of available foundation posts, raising serious concerns about the capacity and foresight of the UK Foundation Programme Office (BMJ, 2024). This paradox of simultaneous oversupply and shortage has been attributed to poor long-term workforce planning and underinvestment in training infrastructure (BMJ, 2024). Consequently, many early-career doctors find themselves in professional limbo: qualified yet unable to progress. This leads to frustration, financial strain, and, in some cases, emigration.

The consequences of this employment insecurity are not only economic but also psychological. A 2025 BMA survey found that almost 70% of GPs reported stress or anxiety linked to underemployment, with many describing the experience as rejection after years of training (BMA, 2025). These experiences reflect a broader trend of labour market casualisation within the NHS, in which even highly skilled professionals face unstable, unpredictable working conditions. The emotional toll of this precarity is compounded by the erosion of professional identity and purpose, particularly among those who entered medicine expecting stability, respect, and long-term career development.

The challenges facing junior doctors in the UK reflect deeper structural issues within the NHS and the medical profession. Recent industrial action has renewed focus on pay erosion and working conditions. The ongoing undervaluation of junior doctors, evidenced by stagnant wages, unpaid labour, and insecure employment, reveals not only policy failures but also a wider process of deprofessionalisation (Bloom, 2002). Theoretical frameworks such as Bloom's concept of deprofessionalisation and Bourdieu's (1991) notion of symbolic violence illustrate how these pressures are both externally imposed and internally normalised, particularly among those from less privileged backgrounds.

The lived experiences of junior doctors, marked by instability, burnout, and a loss of professional identity, challenge the enduring perception of medicine as a secure and prestigious career. Instead, a workforce caught between high expectations and diminishing institutional support emerges. The symbolic rebranding of junior doctors as resident doctors in 2024, while intended to affirm their professional status, has been criticised as superficial without meaningful structural reform (BMA, 2025).

Despite a historic six-day strike in January 2024 and a subsequent agreement for a 22.3% pay rise over two years, junior doctors remain more than 20% below 2008 pay levels in real terms (BMJ, 2024). The continuation of industrial action into late 2024 and 2025, with 98% of junior doctors voting to extend their strike mandate, underscored the depth of dissatisfaction and the urgency of reform (BMA, 2025). These developments underscore the need for more than temporary concessions; they necessitate a fundamental re-evaluation of how the NHS values, supports, and structures the careers of its future medical professionals. Without such reform, the profession risks losing its brightest talent and eroding the very foundations of trust and care on which the NHS is built.

The Challenges that Medical Students Face.

Medical education is a multifaceted and demanding process. Students engage in textbook learning while also confronting the human discomforts associated with examinations and close encounters with death and dying. The balance between clinical responsibilities and personal identity is delicate to maintain. As Underman states, medicine is a field:

> In which personhood, for patient and trainee, is reworked or vacated entirely, death is a daily fact, and the body is cut into and opened in ways that violate many deeply held cultural values (Underman, 2020:1).

Consequently, medical trainees must navigate internal changes and academic pressures while developing the skills to treat and communicate with patients. These challenges can be exacerbated or mitigated by the support trainees receive from university and clinical staff, as well as their peers. Relationship management is key to success in medical education, but, from an individual perspective, trainees must navigate these relationships from their social position, informed by a lived history (Skeggs and Loveday, 2015; Bourdieu and Passeron, 1994). Groups such as working-class individuals, disabled people, and those from minority ethnic groups remain under-represented within medical training. Therefore, understanding of the experiences of these groups remains limited (Friedman and Laurison, 2020). As Livesey (2019) discusses, those at the top of the social order – white, male, heterosexual, able-bodied subjects – remain the norm against which the success of ‘other’ trainees is compared. However, when they experience emotional and psychological challenges, many students describe ‘feeling bad or finding it harder to concentrate’ (Timm, 2014, p. 6).

It is also common for medical students to receive disrespectful treatment from other medical colleagues. In fast-paced clinical environments, trainees are often seen as an inconvenience by more experienced colleagues. Rather than being regarded as valuable members of a multi-disciplinary team, medical students are often disrespected and considered not yet deserving of authority (Jenkins, 2021; Brosnan and Turner, 2009). Trust in an organisation depends on the ability to rely on the actions and work of others within the field (Bell et al., 2020). As a result of the lack of trust in these cultures and the potential risks to future career

prospects, medical students are hesitant to report any disrespectful treatment (Hodges, 2014; Bell et al., 2020).

Consequently, mental health often deteriorates during medical school and continues to decline when trainees enter the workforce (Moir et al., 2018: 324). The impact of experiences in medical education extends beyond the official training period. Research shows a significant correlation between ‘poor mental health and low career satisfaction in those who had been harassed or belittled’ (Timm, 2014, 6). Emotions influence success at all stages of medical education. Trainees who feel respected and supported by their educators can experience a sense of belonging in their chosen field. Doctors' confidence in medicine can be strongly shaped by the emotions experienced during years of training. Emotions are ‘subjective states accompanied by physiological reactions and responses to some conditions, actions, and events’ (Hayat et al., 2020: 2). Positive experiences can foster positive emotions, which in turn can enhance learner engagement, ability, and academic achievements. Conversely, negative experiences and emotions can lead to demotivation, impair cognitive learning ability, and result in complete disengagement from studies (Hayat et al., 2020). Recent studies have shown that environmental factors within medical schools can foster a sense of freedom and respect.

Supportive environments are more likely to foster higher levels of self-efficacy. ‘Academic self-efficacy’ (Hayat et al., 2020: 2) refers to a student's belief in their potential and the likelihood of a successful academic outcome. Klassen and Klassen (2018: 77) suggest that ‘self-efficacy pertains to beliefs about one's capabilities’ regarding future goals. They further suggest that self-efficacy should be considered separately from self-confidence, which they associate more with past events than with future aspirations (Klassen and Klassen, 2018).

As Underman (2020) suggests, modern medical training programmes now place greater emphasis on emotions. Pedagogical advances extend beyond the traditional focus on diagnosing and treating disease, anatomy, death, and dying to include new understandings of trainees' feelings and those of their patients (Underman, 2020; Hayat, 2020). This represents a positive change; however, the extent to which feelings can be prioritised within a neoliberal system remains uncertain. An ethos of lifelong learning and reflection underpins educational improvement initiatives. Nonetheless, marketised educational environments are so ‘externally motivated, so surveillance orientated’ (Hodges, 2014: 363) that students experience constant pressure to perform and succeed.

Increasingly, self-reflection is used in medical education, helping students recognise their ‘struggles as well as their successes’ (Cunningham et al, 2018: 892). The process has revealed ‘themes of changing identity, conflict, and uncertainty’ (Cunningham et al, 2018: 892). Therefore, professional socialisation is not just about becoming a doctor or belonging to the profession. It promotes understanding of how roles are perceived, the emotions linked to the profession, and how students learn to navigate the field (Hafferty, 1988). This navigation is further complicated by unspoken rules and cultures within the profession, often called the hidden curriculum, an often-overlooked aspect of medical education (Brosnan and Turner, 2009). The hidden curriculum is a ‘largely invisible set of influences operating at the level of the structure and culture of the teaching and learning environment’ (Jaye et al, 2006: 143). These unseen rules and cultures play a key role in shaping a medical student's confidence in themselves and their abilities.

The social positioning of both doctor and patient is complicated by seniority and social background. Patient-centred models of care are considered crucial in medical education. As Towle suggests, ‘cultural competence in medicine’ (Towle, 2021: 3) refers to the necessity of treating patients equitably regardless of social or cultural background. However, as this paper shows, medical students face many emotional and psychological challenges. The changes required to develop from a student to a clinician are apparent. Yet some cultures within the field of medicine, such as the existing hierarchy and bullying, contribute to the ordinary stresses experienced by students in other disciplines.

Furthermore, students have reported that patient-centredness is not explicitly taught within the curriculum and that the curriculum remains focused on ‘disease-based perspectives’ (Towle, 2021: 3). The ability to build patient relationships is another crucial part of the role that trainees must learn on the job. Doctor-patient relationships are central to good healthcare, yet the reality of these relationships remains inequitable. Officially, all patients receive the same care; however, Sointu's (2016) research reveals that trainee perceptions of good and bad patients indicate bias in practice. Patients considered good tend to conform to medical opinions, follow treatment plans, and are perceived as understanding and trusting medical professionals. By comparison, bad patients seem resistant to medical advice, have limited knowledge of their medical history, and make poor choices. These perceptions often mean that patients seen as good are afforded more positive feelings from clinicians, whereas bad patients cause frustration for the profession. Narratives of the deserving and the undeserving begin to emerge in research.

Moreover, studies have shown that patients are categorised as good or bad. ‘Good’ patients are considered compliant with expectations, making the doctor's role more straightforward. By contrast, ‘bad’ patients are seen as less compliant with ‘competent agencies’ (Dingwall and Murray, 1983: 131). Despite narratives of patient choice, professional control can be a mechanism for maintaining hierarchy. The notion that doctors know best remains evident in studies of medical education and is critiqued as part of the culture of professional socialisation (Jenkins et al., 2021).

Consequently, rather than recognising health inequalities as a wider societal problem, the medical profession often, in practice, considers non-compliance a personal choice. Despite the shift from patients being passive recipients of paternalistic medicine to being enabled to manage their care, the recognition of good and bad patients raises questions about whether the power dynamics that have historically existed have been undone (Underman, 2020). As healthcare develops, rather than doctors knowing best, doctors are asked to ‘respect the rights of patients to be fully involved in decisions about their care’ (GMC, 2003: 9). If moral judgements about good and bad patients persist, it is doubtful that all patients would be good enough to make decisions about something as important as medical care.

Consequently, medical students face a myriad of emotional and psychological challenges, as this paper shows. The profession has, for centuries, been a hierarchical closed shop. The first stage of a trainee’s clinical training involves understanding the social and cultural norms and ‘becoming’ a member of an unfamiliar environment. Consequently, acceptance of cultural norms, even when they cause distress, has become a normalised part of the training process for many. These challenges can lead to uncertainty among medical students, causing them to lack confidence in their abilities and even leading to mental health issues (Underman, 2020; Brosnan and Turner, 2009).

Unsurprisingly, medical students can begin to experience a decline in empathy towards their patients. When working with cadavers, students often find ways to detach themselves (Hafferty, 1988). Reduced empathy remains evident when discussing the concept of the 'bad' patient. This disregard for patients, seen as the cause of their illness through poor lifestyle and personal choices, can become embedded in narratives of patient care (Brosnan and Turner, 2009). These ideas are a consequence of a neo-liberal ideology that permeates wider society, in which those considered non-compliant are seen as 'choosing' poor health. Medical training encourages students to leave their 'lay' identity behind in pursuit of belonging to the medical community. Therefore, identity, emotions, and a sense of belonging intersect, creating emotional and psychological challenges for students alongside the complex prescribed curriculum.

This raises important questions for further sociological analysis about the values underpinning medical training and practice. Specifically, it prompts reflection on the extent to which empathy and relational care are prioritised within the medical profession, and on whether it is realistic or achievable to train all students to attend to patients as whole persons rather than as clinical cases. The broader challenge is to develop a medical system that is genuinely representative of the diverse communities it serves, enhances the quality of patient care, and fosters a more humane and sustainable working environment for medical staff.

These questions are particularly complex in medicine because professional training is structured to socialise trainees into established institutional cultures, norms, and hierarchies. Professional assimilation often valorises detachment, resilience, and conformity, leaving little room for difference. Within this context, social class has received relatively little attention in the medical education literature, as medicine is frequently portrayed as a predominantly middle-class profession in which students are assumed to fit naturally. Examining the experiences and emotional lives of working-class trainees therefore addresses a significant gap in the field, offering new insights into how class shapes professional formation, belonging, and care practices in medical education.

Inside the Clinic - Navigating the Medical Field as Working-Class Students

The chapter begins by analysing the symbolic and emotional significance of entering the clinical setting, particularly in the cadaver laboratory. It then considers how classed identities influence students' perceptions of hierarchy, authority, and exclusion. Lastly, it discusses how working-class students engage with patients and address health inequalities, often offering insights that challenge dominant biomedical narratives.

It will then examine the shift from pre-clinical to clinical training, a crucial moment in the formation of a medical identity. For working-class students, this shift is not merely an educational milestone but a profoundly classed and emotional experience. It involves entering environments filled with middle-class norms and expectations, where the ability to fit in is often as vital as clinical skill (Reay, 2017; Skeggs and Loveday, 2015).

While medical education literature has increasingly recognised the emotional labour and psychological toll of clinical training (Moir et al, 2018; Hayat et al, 2020), the specific experiences of working-class students remain understudied. Furthermore, this chapter applies Bourdieu's concepts of habitus, capital, and symbolic violence (Bourdieu, 1986;

1990; 1994) to explore how these students navigate the clinical environment, learn to display professionalism, handle emotional conflict, and negotiate belonging in spaces that often feel unfamiliar. The clinical environment is a powerful site of professional socialisation. It is where students begin to embody the role of the doctor, not only through technical skill but through performance, language, and emotional regulation. For working-class students, this transition is often fraught with tension. As Reay, poignantly observes, clinical placements are ‘another stage in a difficult and painful struggle to be accepted and included in a middle-class space’ (2017:153). The clinic is not a neutral learning environment; it is a cultural field in which certain dispositions are rewarded, while others are marginalised (Bourdieu, 1990).

One of the earliest and most emotionally charged experiences in clinical training is the encounter with the cadaver. A cadaver is a deceased person’s body used by medical students, researchers, and professionals to study anatomy, practice surgical techniques, and learn about the human body practically. In medical education, cadavers are often employed in dissection labs, especially during the early years of training, to help students understand the structure and function of organs, muscles, bones, and other bodily systems (Hafferty, 1988). Dissection is often seen as a rite of passage, a moment where students begin to shed their lay identities and adopt the clinical gaze. However, this moment is not experienced equally. Prentice describes the cadaver as ‘neither a person nor a thing. It is both and neither’ (2016: 257), highlighting the ontological ambiguity that students must navigate. For many, especially those without prior exposure to death or clinical environments, this encounter can be overwhelming. This often emotionally charged interaction can be the beginning of the process of detachment for these students.

Hafferty’s (1988) ethnographic research investigating cadaver laboratories shows how students often use humour and emotional detachment as coping mechanisms to deal with the discomfort of working with the dead. However, these strategies also help to reinforce exclusion and maintain hierarchical dynamics within the learning environment. Specifically, Hafferty noted that male students frequently used dark humour to assert dominance. In contrast, female students and those perceived as less confident, often from working-class backgrounds, were portrayed as emotionally fragile or unsuited to the profession (Hafferty, 1988: 344–356). These patterns reflect wider forms of symbolic violence within medical education, a field historically influenced by masculine norms where emotional expression is tightly controlled and often associated with class.

Beyond the anatomy laboratory, the clinical environment is shaped by a complex set of informal norms and procedural expectations. Students must quickly learn how to navigate ward hierarchies, address senior staff properly, and show deference through their behaviour and communication. These expectations also encompass the practical aspects of clinical work, including proficiency in operating hospital computer systems, referring patients for diagnostic tests, and accurately completing documentation. Such skills are rarely taught explicitly, but they are vital for being perceived as capable and professional. For students from working-class backgrounds, who may lack the cultural capital to absorb these norms naturally, the learning curve can be particularly steep (Brosnan and Turner, 2009; Latham, 2025).

As Bourdieu (1986) argues, cultural capital, such as fluency in institutional language, confidence in professional settings, and the ability to present oneself with ease, plays a pivotal role in educational and occupational success. These embodied practices form part of

what Bourdieu (1994) terms symbolic mastery: the ability to navigate and reproduce the symbolic order of a field. Without this mastery, students risk being misrecognised as lacking competence, regardless of their academic or clinical abilities. Addison and Mountford (2014) and Friedman and Laurison (2020) similarly highlight that being able to walk the profession's talk is often a prerequisite for inclusion and advancement in elite domains such as medicine. This discord between personal identity and professional expectations can leave students feeling they are constantly performing, suppressing aspects of themselves to fit into a culture that was not designed for them. This emotional labour is compounded by the pressure to succeed, not to show weakness, and to prove one is worth in a competitive environment (Hodges, 2014; Klassen and Klassen, 2018).

However, despite these challenges, working-class students often bring a deep sense of purpose, flexibility, and empathy. Their presence in the clinic is not just a personal achievement; it is a challenge to the status quo. As Crew (2025) notes, working-class professionals often develop unique coping strategies and forms of resistance that enable them to survive and even succeed in hostile environments. These students are not merely adapting to the clinic; they are transforming it, bringing with them values and insights that contest narrow definitions of professionalism and success.

Classed Encounters and Cultural Dissonance

As working-class students delve deeper into clinical settings, the difficulties of navigating unfamiliar cultural landscapes become more evident. The clinic is not only a place for medical learning but also a space where social class is subtly conveyed and assessed. Expectations regarding speech, dress, and behaviour often mirror middle-class standards, which can marginalise those who do not naturally fit in. These cultural expectations are seldom made explicit, yet they influence how students are perceived and how they view themselves.

In the clinical setting, students are expected to adopt a professional persona that aligns with institutional ideals: confident but not overconfident, articulate but not overly challenging, emotionally composed yet empathetic (Beagan, 2005; Baxter et al., 2015). For working-class students, these expectations can feel alien or even contradictory to their lived experiences. This cultural dissonance is not merely theoretical. Beagan’s study of classism in Canadian medical schools found that working-class students often experienced subtle but persistent marginalisation. They reported feeling ‘out of place.... being judged for their accents, clothing, or lack of cultural capital, and struggling to find mentors who understood their backgrounds (2005: 779). These findings resonate with UK-based research, where widening participation initiatives have increased access to medical education but have not dismantled the cultural hierarchies embedded within it (Baxter et al, 2015). The result is often a form of embodied anxiety. Students may second-guess their speech, appearance, or behaviour, fearing that any misstep will confirm their outsider status. This anxiety is not simply cognitive; it is felt in the body, it is a hyper-awareness of being watched and judged (Baxter et al, 2015). Skeggs (1997) describes this as the ‘struggle for value’, a constant negotiation of self-worth in environments that do not recognise or reward working-class dispositions. In such spaces, the clinic becomes a site of symbolic violence, where students internalise the idea that they must change who they are to succeed (Bourdieu, 1994).

This embodied anxiety is frequently reframed in elite professions, including medicine, as imposter syndrome. Rather than being understood as a rational and human response to exclusionary institutional cultures, it is individualised and psychologised. Students are encouraged to see their discomfort as a personal failing, a lack of confidence, or a lack of resilience, rather than as a symptom of structural inequality. As Addison, Breeze, and Taylor (2022) argue, imposter syndrome in higher education often masks the effects of classed and gendered exclusion, shifting the burden of adaptation onto the individual rather than interrogating the institution's culture itself. In this way, the emotional toll of navigating elite spaces is depoliticised, and the responsibility for 'fitting in' is placed squarely on the shoulders of those who were never meant to belong.

The hierarchical nature of medical training compounds these pressures. Clinical environments are characterised by steep power gradients, in which students are often positioned at the bottom of the professional ladder. While this is true for all trainees, working-class students may experience this hierarchy more acutely, as it intersects with broader social inequalities. Bell et al document how bullying and harassment are common in medical education, with students often reluctant to report mistreatment due to fear of reprisal or damage to their careers (2020: 465). This culture of silence disproportionately affects those who already feel marginalised.

Becker's (1977) classic ethnography, *Boys in White*, remains strikingly relevant in this context. He describes how medical students quickly learn the rules of the game, not just clinical knowledge, but how to behave, speak, and align themselves with the dominant culture of medicine; those who fail to conform risk being labelled as unprofessional or unfit. For working-class students, this often means suppressing aspects of their identity to survive. Despite these challenges, many students find ways to resist or subvert the dominant norms. Some draw on their working-class backgrounds as a source of strength, using their experiences to connect with patients or question taken-for-granted assumptions within the profession. Others form peer networks or seek out mentors who validate their identities and experiences. These acts of resistance are not always visible, but they are vital. As Loveday argues, working-class students often engage in 'affective practices' that challenge the deficit narratives imposed upon them (2015:1142).

In this way, the clinic becomes both a site of struggle and a space of potential transformation. While the dominant culture may seek to assimilate students into a narrow model of professionalism, working-class students bring with them alternative ways of knowing, relating, and caring. Their presence challenges the profession to become more inclusive, not only in terms of who can become a doctor, but also in how medicine is practised and understood.

Patients as People: Empathy, Class, and Health Inequalities

For working-class medical students, the clinical encounter often resonates on a deeply personal level. Unlike the dominant biomedical model, which tends to fragment patients into symptoms and diagnoses, these students frequently approach patients as whole people, whose health is shaped by complex social, economic, and cultural realities. This orientation is not simply a matter of personality or preference; it is rooted in lived experience. Many working-class students have grown up in communities where illness is entangled with

poverty, housing insecurity, and precarious work, and where navigating healthcare systems is often fraught with mistrust and marginalisation (Beagan, 2005; Marmot et al., 2020).

This background equips students with relational insight that is often absent from formal medical training. Their ability to empathise with patients who are struggling, whether financially, emotionally, or socially, is grounded in a shared understanding of structural disadvantage. Rather than viewing non-compliance as a personal failing, they are more likely to recognise it as a rational response to constrained choices. This perspective aligns with Yosso's (2005) concept of 'community cultural wealth', a set of assets developed through navigating inequality, including linguistic dexterity, resilience, and a critical awareness of institutional power.

Such insights are particularly valuable in a healthcare system increasingly shaped by neoliberal logics of efficiency and individual responsibility. In this context, patients are often categorised as 'good' or 'bad' according to their adherence to medical advice, with little attention to the social conditions that shape their behaviour. As Sointu (2017) notes, these moral judgements are deeply classed, reinforcing a culture in which middle-class norms of health literacy and deference are rewarded, while working-class patients are pathologised. Working-class students, by contrast, are often more attuned to these dynamics and better placed to challenge them.

This capacity to see patients as people, rather than problems, is not always recognised in the formal curriculum. While medical schools increasingly promote the language of patient-centred care, the hidden curriculum often tells a different story, one in which emotional detachment, clinical distance, and efficiency are implicitly valued over empathy and relational care. Michalec (2011) argues that the hidden curriculum can subtly erode students' capacity for empathy by reinforcing hierarchical and depersonalised models of care. For working-class students, this creates a tension between their instinctive approach to patient care and the professional norms they are expected to adopt (Becker, 1977; Jenkins et al., 2021).

Despite these pressures, many working-class students actively resist the erosion of empathy. Their commitment to equitable care is often sustained by a strong moral purpose and a desire to give back to communities like their own. Balmer et al. (2017) highlight that working-class students draw on community and resourcefulness not only to succeed academically but also to build meaningful relationships with patients. These students often bring a grounded, humble approach to clinical work, one that prioritises listening, respect, and mutual understanding.

However, this orientation is not always supported by institutional structures. Towle (2021) observes that while empathy is often discussed in theory, it is rarely modelled in practice or rewarded in assessments. This disconnect can be particularly disillusioning for students who entered medicine with a strong sense of vocation. Foreshew and Al-Jawad (2022) further argue that class elitism in medical education can marginalise the very perspectives most needed to address health inequalities, silencing students who challenge dominant norms. However, it is precisely these students who are best placed to lead a shift in how medicine understands and responds to inequality. Their lived experience enables them to recognise the social roots of illness and to advocate for care that is not only clinically effective but also socially just. As the Marmot Review (Marmot et al., 2020) makes clear, addressing health

inequalities requires more than individual interventions; it demands a systemic understanding of how social conditions shape health outcomes. Working-class students, by virtue of their backgrounds, are uniquely positioned to bring this understanding into the clinic.

This relational and socially attuned approach to care is not merely a personal inclination—it reflects a broader reimagining of what it means to be a doctor. Rather than conforming to the emotionally neutral, efficiency-driven model often valorised in clinical training, many working-class students draw on their lived experiences to offer a more humane and inclusive vision of medicine. Their understanding of empathy is not static or innate but is shaped by their biographies and the institutional cultures they navigate. As Yang et al. (2025) demonstrate, empathy in medical education is a dynamic, context-sensitive practice, influenced by both personal history and the norms of the training environment. Similarly, Wiltshire, Lee, and Williams (2019) show that social class plays a crucial role in shaping how patients and practitioners perceive health, illness, and care. These insights reinforce the idea that working-class students are not merely adapting to the medical profession; they are actively reshaping it from within, challenging its assumptions and expanding its capacity to respond to the realities of patients' lives.

Identity, Belonging, and Resistance

The clinical environment is not only a space of learning and care but also a powerful site of identity formation. For working-class medical students, this process is often marked by tension and contradiction. As they move through clinical placements, they are expected to internalise the norms, values, and behaviours of the medical profession, often shaped by middle-class assumptions about competence, confidence, and professionalism. This process of professional socialisation can create a profound sense of dislocation, as students are asked to perform identities that may feel at odds with their own.

This feeling of not belonging is reinforced by the hidden curriculum, which conveys powerful messages about who fits in and who does not. As Hafferty and Hafler (2011) argue, the hidden curriculum operates through informal interactions, institutional hierarchies, and unspoken expectations, shaping students' sense of legitimacy and self-worth. For working-class students, these messages can be profoundly alienating, especially when they are reinforced by experiences of microaggressions, exclusion, or outright discrimination (Bell et al., 2020; Timm, 2014). However, despite these challenges, many students find ways to resist and reaffirm their identities. Some do so by forming supportive peer networks, where they can share experiences, validate each other's struggles, and develop collective strategies for survival. Others may speak out against injustice, advocate for patients from marginalised backgrounds, or refuse to conform to narrow models of professionalism (Loveday and Skeggs, 2012).

Importantly, this resistance is not always overt; that would be too much of a professional risk. Often, it takes the form of quiet persistence, holding on to one's values in the face of pressure to assimilate. As Crew (2025) notes, working-class professionals often develop subtle, emotionally intelligent strategies for navigating elite spaces, allowing them to maintain a sense of integrity while also succeeding within the system. These forms of resistance are not only personally sustaining; they are also politically significant, as they challenge the medical profession's cultural homogeneity and open space for more inclusive

ways of being a doctor. In this way, the clinical environment becomes a site not only for professional formation but also for personal transformation. For working-class students, the journey through medical training is not simply about acquiring knowledge and skills—it is about negotiating identity, asserting belonging, and imagining new possibilities for what medicine could be. Their presence in the clinic is a quiet revolution, one that has the potential to reshape the profession from within.

This chapter has examined the complex and often contradictory experiences of working-class medical students as they navigate the clinical environment. From their first encounters with cadavers to the development of relationships with patients and peers, these students are engaged in an ongoing process of negotiating identity, belonging, and professional legitimacy. The clinic, far from being a neutral learning space, is shown to be a site of cultural reproduction, where middle-class norms are embedded in both the formal and hidden curricula. However, many working-class students do not merely adapt to these norms; they challenge and reshape them. Their lived experiences give them a unique capacity for empathy, a critical awareness of structural inequality, and a relational approach to care that is often missing from mainstream medical training. These qualities are not consistently recognised or rewarded within the institution, yet they are essential to the future of a more inclusive and socially responsive medical profession.

Throughout this chapter, I have considered how working-class students draw on community cultural wealth (Yosso, 2005), resist symbolic violence (Bourdieu, 1994), and engage in affective practices that assert their value in spaces where they are often made to feel marginal (Loveday, 2015; Skeggs and Loveday, 2012). Their presence in the clinic is not only a personal achievement but also a political act, one that disrupts the reproduction of elitism in medicine and opens new possibilities for what it means to be a doctor.

As this thesis moves into the discussion chapters, the focus will shift from the structural and cultural dynamics of clinical training to the lived experiences of working-class medical students. Through their narratives, this thesis will examine how they navigate the clinic, not only as learners but as emerging practitioners delivering patient care. These students provide rich, reflective accounts of what it means to care for others while navigating their sense of belonging in a profession that has historically excluded individuals like them. Their stories illuminate how empathy, identity, and resistance are enacted in real time, in real spaces, and with real consequences.

These narratives will also reveal how working-class students draw on their histories and values to shape their clinical practice, often prioritising patient dignity, relational care, and social justice in ways that challenge dominant models of professionalism. In doing so, they not only humanise the clinical encounter but also reimagine the kind of doctor they want to become. The discussion chapters will therefore not only document their struggles but also celebrate their agency, insight, and transformative potential within the field of medicine.

Methodology

Having established the historical and sociological context of class-based inequality in medical education, this chapter details the methodological approach used to study these issues in real-world settings. It provides the framework for exploring the lived experiences of working-class medical students in the UK. The chapter starts with explaining why a

qualitative, mixed-methods approach was chosen, then describes the participant recruitment process, sampling criteria, and data collection methods.

This study employs a qualitative, interpretivist epistemological framework, drawing on critical sociological and educational research concerning social class, inequality, and institutional authority (Reay, 2015; Braun and Clarke, 2019). It conceptualises knowledge as socially constructed, partial, and context-dependent, rather than entirely neutral or objective. In this perspective, social class is seen not as a static or solely economic category but as a relational, lived experience moulded by biography, social positioning, and ongoing interactions with institutions (Skeggs, 1997; Reay, 2017). This epistemological approach is especially appropriate for exploring working-class experiences in elite settings, where processes of inclusion, exclusion, and recognition often occur subtly through cultural norms, expectations, and everyday practices (Reay et al., 2001; Bathmaker, 2018).

This study's methodological approach draws on Bourdieusian sociology, emphasising the dynamic interplay between structural conditions and personal agency (Bourdieu, 1986; Bourdieu, 1990). It employs concepts such as habitus, symbolic violence, and misrecognition to analyse how dominant institutional norms come to be perceived as natural and how inequalities persist through seemingly ordinary interactions (Reay, 2015). As Burawoy highlights in his discussion with Bourdieu, symbolic violence is better understood not as explicit power but as habitual, underlying processes through which power is internalised and rendered invisible, making lived experience a key focus of sociological investigation (Burawoy, 2019). Consequently, participants' narratives are viewed not as straightforward reflections of reality but as context-dependent accounts that reveal the influence of institutional power, legitimacy, and belonging.

This study, aligned with Bourdieusian theory, also incorporates Yosso's (2005) Community Cultural Wealth framework as a key epistemological approach. Yosso challenges deficit-oriented views of working-class and marginalised students by emphasising their existing forms of capital rather than their shortcomings. Her framework illustrates how dominant institutions often overlook the cultural, relational, and resistant resources that marginalised groups use to succeed in elite settings. This asset-based perspective complements the interpretivist approach adopted here, affirming participants' narratives as valid insights into institutional power, inequality, and belonging, instead of viewing working-class experiences as lacking or deficient (Yosso, 2005; Loveday, 2015).

Drawing on Yosso's framework supports an understanding of class that attends to aspirational, familial, navigational, and resistant forms of capital as lived and contextually embedded, rather than as abstract or individualised attributes (Yosso, 2005). It also reinforces the decision to prioritise qualitative methods that capture the experiential and affective dimensions of educational and professional trajectories (Reay, 2004; Bullock, 2016). When brought into dialogue with Bourdieusian concepts of symbolic violence and misrecognition, this approach enables a nuanced analysis of how working-class medical students both encounter structural constraints and actively mobilise cultural resources to persist within a profession historically aligned with middle-class norms (Skeggs and Loveday, 2012; Jagger, 2025).

Reflexivity is key to this approach. As qualitative researchers regularly emphasise, knowledge arises from the researcher's interpretive efforts, influenced by their positionality, power dynamics, and emotional involvement. (Braun and Clarke, 2019; Coyle et al., 2021).

As a working-class academic researching working-class medical students, the researcher occupies a position of partial insider status, sharing aspects of classed experience while also holding institutional authority within higher education. Rather than treating this positionality as a source of bias to be minimised, reflexivity is understood as a methodological resource that enhances analytical and ethical rigour (Skeggs, 1997). This approach fosters attentiveness to moments of resonance, dissonance, and potential over-identification. It aligns with class-sensitive qualitative research that emphasises care, responsibility, and reflexive accountability in representing marginalised professional groups (Jagger and Fry, 2023).

This epistemological orientation underpins the methodological choices throughout the study. Semi-structured interviews were selected to enable participants to articulate meanings in their own terms and to explore identity, emotion, and classed experience (Bullock, 2016). Reflexive thematic analysis was employed to support interpretive engagement with participants' narratives, prioritising depth, patterning, and theoretical insight over claims of representativeness or generalisability (Braun and Clarke, 2006; Braun and Clarke, 2019). The aim is therefore not to produce universal claims about all working-class medical students, but to generate analytically transferable insights into how class operates within medical education as an elite institutional field (Reay, 2017).

This epistemological positioning informed the recruitment strategy, data collection methods, and analytical approach outlined below, shaping both the selection of participants and the interpretive framework through which their narratives were examined. The choice to use a qualitative mixed-methods approach, combining an online qualitative survey with semi-structured interviews, was motivated by the desire to capture the complexity and nuances of participants' experiences. Working-class students often navigate medical education shaped by intersecting aspects of class, identity, and institutional culture. A qualitative approach was therefore crucial for uncovering the emotional, relational, and structural dynamics that quantitative methods might miss (Beagan, 2005; Reay et al, 2009).

The two-phase design enabled both breadth and depth. The online survey offered a flexible and accessible way for participants to share their stories, while the follow-up interviews allowed for a deeper investigation of emerging themes. This structure also accommodated the busy schedules of medical students by providing multiple modes of participation, enabling them to engage at their own pace and convenience. Recognising the time pressures from clinical placements, academic assessments, and personal responsibilities, the research plan prioritised flexibility, autonomy, and minimal disruption to participants' routines.

Throughout the chapter, each methodological choice is supported by references to relevant literature on widening participation, social class, and qualitative research in medical education. The chapter also demonstrates how ethical integrity and reflexivity were integrated into the research process to ensure that participants' voices were presented with care, respect, and authenticity.

Participants and Sampling

To improve accessibility, a variable recruitment approach was adopted. In addition to outreach through medical schools and widening participation offices, participants were recruited via online platforms, specifically X (formerly Twitter) and LinkedIn. These platforms

were selected for their ability to reach a broad, diverse, and geographically dispersed audience, including students who may not have been involved in formal widening participation schemes or institutional networks (Clark and Hordosy, 2019; Braun et al., 2020).

Recruitment posts were distributed through professional networks, broadening access for diverse groups and medical education communities. Posts were carefully crafted with inclusive, affirming language and clear eligibility criteria to encourage self-identification among first-generation and working-class medical students. This strategy aimed to lower barriers to participation by helping individuals recognise their experiences within the study's scope, rather than relying solely on institutional labels or gatekeeping mechanisms (Baxter et al., 2015; Reay, 2017).

This approach aligned with research advocating the use of digital tools in qualitative research to access underrepresented voices and improve participant autonomy (Braun et al., 2020). It also reflected the value of flexible, participant-centred methods that prioritise accessibility and inclusivity (Bullock, 2016). Furthermore, it resonated with scholarship emphasising that digital platforms function not only as recruitment tools but also as spaces where students negotiate identity, belonging, and legitimacy in higher education (Clark and Hordosy, 2019; Cribb and Bignold, 1999).

To uphold ethical integrity, all online interactions complied with strict standards of informed consent, confidentiality, and data protection. Participants received detailed information sheets and consent forms and were allowed to ask questions or withdraw at any point. The online recruitment process promoted greater participant autonomy, allowing individuals to engage with the research on their own terms and schedules. This blended recruitment approach was particularly effective in reaching students who may have been navigating complex educational pathways or who felt peripheral to mainstream institutional narratives. Using both formal and informal networks, the study sought to amplify the voices of those frequently marginalised in discussions of medical education and to promote a more inclusive and representative view of working-class students' experiences (Boursicot and Roberts, 2009; Reay et al., 2001).

This study views social class as a relational and lived experience rather than a fixed socio-economic label, as explained in the introduction. Although structural indicators such as being a first-generation university student, attending non-selective state schools, and lacking family connections to the medical field were used for recruitment purposes, they served only as entry criteria, not as definitive class identifiers. Aligning with sociological theories that focus on habitus, symbolic violence, and misrecognition (Bourdieu, 1986; Reay, 2015), class was analysed as something shaped by experience, interaction, and institutional context. This approach-maintained consistency with the class's conceptual framework, outlined earlier in the thesis, and with the operational decisions made during recruitment, data collection, and analysis.

Participants were recruited from all stages of medical training, including those enrolled in widening access or foundation programmes. This inclusive approach ensured that the study captured a broad spectrum of experiences across the medical education continuum, from pre-clinical to clinical years. The inclusion criteria focused on students who were the first in their families to attend university and who had no personal or familial connections to the medical profession. These criteria were selected to reflect structural barriers to access and

to align with existing research that highlights the significance of first-generation status and the absence of social capital in shaping educational trajectories and professional aspirations (Nicholson and Cleland, 2017; Latham et al., 2025; Reay, 2017).

For the second phase, semi-structured interviews were conducted using a maximum variation sampling strategy. This approach, a subtype of purposive sampling, seeks to capture a wide range of perspectives by including participants with diverse backgrounds and experiences (Miles and Huberman, 1994). The aim was not to achieve statistical generalisability but to explore the breadth of working-class student experiences in depth. This strategy was particularly effective in identifying patterns and contrasts across different stages of training, demographic profiles, and institutional contexts.

Table 1	Participant pseudonym	Year of Study	Age range	Gender	Commuter Student	Family Carer	Ethnicity	Interview/ Survey
1	Chantal	Year 2	21-25	Female	Yes	Yes	Mixed Caribbean/British	Interview
2	Nicole	Year 4	21-25	Female	Yes	No	White/British	Interview
3	Josie	Year 2	21-25	Female	No	No	White/British	Survey
4	Meg	Year 4	21-25	Female	Yes	Yes	White/British	Interview
5	Joe	Year 3	26-30	Male	Yes	Yes	White/British	Interview
6	Lucy	Year 2	21-25	Female	No	No	White/British	Interview
7	Sophie	Year 3	21-25	Female	No	No		Interview
8	Zena	Year 3	26-30	Female	No	Yes	Pakistani/British	Interview
9	Leon	Year 3	36-40	Male	No	Yes	White/British	Interview
10	Jack	Year 1	21-25	Male	Yes	No	White/British	Survey
11	Pete	Year 2	21-25	Male	Yes	No	White/British	Interview
12	Louise	Year 3	21-25	Female	Yes	No	White/British	Survey
13	Ted	Year 2	21-25	Male	No	No	White/British	Survey
14	Joanna	Year 3	21-25	Female	No	No	White British	Survey
15	Natasha	Year 3	21-25	Female	No	No	White British	Interview
16	Alex	Year 4	21-25	Female	No	No	White/British	Interview
17	Josh	Year 2	21-25	Male	No	No	Black/Caribbean	Interview
18	Lily	Year 5	26-30	Female	Yes	No	White/British	Interview
19	Laura	Year 4	21-25	Female	No	Yes	White/British	Survey
20	Stephen	Year 3	31-35	Male	Yes	No	White/British	Survey
21	James	Year 4	26-30	Male	Yes	No	Black/British	Interview
22	Rosie	Year 2	21-25	Female	No	No	White/British	Interview
23	Amina	Year 2	21-25	Female	Yes	No	Asian/British	Interview
24	Callum	Year 5	21-25	Male	No	No	White/British	Interview
25	Chloe	Year 4		Female	No	No	White/British	Interview
26	Mo	Year 4	21-25	Male	Yes	No	Asian/British	Survey
27	Zoe	Year 2	21-25	Female	Yes	No	White/British	Survey
28	Shabina	Year 4	21-25	Female	Yes	Yes	Pakistani/British	Survey
29	Kitty	Year 3	26-30	Female	No	Yes	White/British	Survey
30	Tiffany	Year 5	21-25	Female	Yes	No	White/British	Interview
31	Harvey	Year 2	21-25	Male	No	No	White/British	Survey
32	Sid	Year 3	31-25	Male	Yes	Yes	Asian/British	Survey
33	Jess	Year 3	21-25	Female	No	No	White/British	Interview
34	Tom	Year 4	21-25	Male	No	No	White/Irish	Survey

The final sample comprised 34 undergraduate medical students from all stages of the medical programme (Years 1–5, Table 1). Participants were recruited through purposive

sampling, aligned with widening participation routes, first-generation university status, and the absence of familial connections to medicine. This approach was designed to foreground the experiences of students navigating medical education without access to the social, cultural, and economic resources typically associated with the profession.

Representation was strongest among students in Years 2–4, reflecting a deliberate emphasis on experiences beyond the initial transition and into the sustained navigation of academic and professional cultures. Although only one participant was enrolled in Year 1 and four in Year 5, the overall distribution enabled analysis of how exclusionary practices, misrecognition, and emotional labour accumulate over time rather than as isolated entry-point challenges.

Most participants were aged 21 to 25, with a notable minority of mature students aged 26 to 40, highlighting varied educational paths. These age differences were significant, as mature students often reported additional pressures, such as financial independence, caring responsibilities, and a heightened sense of being different from cohort norms.

The cohort comprised 21 women and 13 men, allowing attention to gendered experiences where relevant while maintaining class as the primary analytic focus. Most participants identified as White British, with representation from Black British, Asian British, Pakistani British, and mixed-heritage backgrounds. While this diversity enabled consideration of how class intersects with other social positions, the predominance of White participants necessitates caution in making claims about racialised experiences, reinforcing the study's focus on analytically rather than empirically generalisable findings.

Two biographical characteristics were particularly prominent in the sample. Almost half of the participants identified as commuter students, typically living at home and travelling to university, while approximately one-third reported ongoing family caring responsibilities alongside their studies. These features were central to the study's analytical focus, shaping participants' access to informal learning spaces, peer networks, and institutional support structures. Commuting and caring roles also intensified experiences of time scarcity and emotional labour, influencing how students engaged with the academic and social dimensions of medical education.

In-depth, semi-structured interviews (n = 20) were the primary method of data collection, enabling detailed exploration of identity, misrecognition, and emotional experience. Survey responses (n = 14) were included to broaden contextual insight and facilitate participation by students whose work or caring commitments limited their availability for interviews. Rather than functioning as a parallel dataset, survey responses complemented interview data by extending the range of student circumstances represented.

The demographic composition of the cohort necessarily shapes the insights produced. The concentration of participants in Years 2–4 foregrounds experiences of sustained institutional navigation rather than the early transition alone, while the prevalence of commuters and carers directs analytic attention to the structural organisation of time, space, and belonging in medical education. Claims throughout the thesis are therefore situated within this specific cohort. They are framed as theoretically and analytically transferable rather than as universally representative of all working-class medical students (see Appendix 1).

Phase One: Online Qualitative Survey

The first phase involved an online qualitative survey designed to elicit rich narrative responses. As Braun et al. argue, qualitative surveys can ‘harness the potential of qualitative data to offer nuanced, in-depth and sometimes new understandings of social issues’ (2020: 1). The survey questions were open-ended and framed to allow participants to articulate their experiences in their own words, capturing individual perspectives, positionality, and the complexity of their trajectories into medical education.

This method was particularly appropriate during the COVID-19 pandemic, when movement restrictions limited in-person data collection. Participants were asked to commit approximately one hour to complete the survey. Despite this time commitment, the survey yielded 14 usable responses. These responses served as a pilot study, informing the development of the interview schedule and helping to identify key themes for further exploration, such as belonging, institutional culture, and emotional labour (Loveday, 2015; Reay, 2015). The iterative use of the survey as a pilot ensured that the interview questions were grounded in participants' lived realities and responsive to emergent concerns.

Although the online qualitative survey was the initial data collection step, it had less impact on the overall dataset than expected. Despite efforts to reach participants via participation networks, medical school mailing lists, and social media, only 14 usable responses were obtained. This limited response underscored various methodological and contextual challenges that reduced the survey's effectiveness. First, the survey depended on voluntary participation from a group already under significant time pressure, academic stress, and emotional strain. Medical students, especially those from widening participation backgrounds, often balance their studies with paid work, commuting, and caregiving. Expecting them to complete a reflective, open-ended survey in their limited free time was unrealistic, exposing a mismatch between the method and the realities of the target population. The survey’s format lacked the relational and dialogic qualities vital for exploring classed experiences in qualitative research. Topics such as belonging, identity, misrecognition, and emotional labour are personal and often require trust and rapport, which an asynchronous, impersonal survey cannot provide.

Consequently, many responses were brief, cautious, and descriptive, offering only partial insights into students’ complex experiences. Second, the survey assumed participants would be comfortable discussing their classed experiences in writing. However, some working-class students might worry about legitimacy, judgment, or saying the wrong thing, thereby further limiting the depth of their responses. Lastly, the limited demographic diversity meant the survey could not stand as a standalone dataset for thematic analysis. Instead, it was primarily a pilot tool that helped develop the interview schedule and identify areas that needed deeper exploration. The survey’s limitations led to a methodological shift toward semi-structured interviews, which provided richer, more nuanced, and emotionally textured data. Rather than seeing the survey as a failure, its shortcomings offered valuable lessons for the research class in elite professional fields, especially at the university level, where negotiations are complex. They highlighted the need for relational, flexible methods that accommodate the time constraints and emotional labour of working-class medical students. These insights improved the design of the second data collection phase and fostered a more reflexive, ethically sensitive methodological approach.

Phase Two: Semi-Structured Interviews

After pandemic restrictions were eased, the second stage of data collection involved semi-structured interviews with twenty participants. These interviews aimed to complement and deepen the survey data by providing richer insights into participants' motivations, challenges, and changing sense of belonging during their medical training. As Bullock (2016) highlights, one-on-one interviews are especially effective for uncovering attitudes, beliefs, and meanings in participants' own words, helping researchers understand how individuals interpret their experiences within broader social contexts.

Semi-structured interviews were chosen for their balance of structure and flexibility. This format allowed for consistent exploration of key topics such as class identity, belonging, institutional culture, and clinical experiences among participants, while also giving individuals space to raise issues important to them. This was particularly important given the sensitive and emotional nature of classed experiences, which often require rapport, conversational space, and trust to be fully articulated. The format enabled participants to tell their stories in their own words and allowed the researcher to probe, clarify, and follow up on emerging themes that were not possible in the survey phase.

The interviews were conducted flexibly to accommodate medical students' busy schedules. All participants preferred online interviews via platforms such as Zoom or Skype, which improved accessibility and reduced the burden of participation. This flexibility was crucial given the ongoing pressures of clinical placements, assessments, and the emotional toll of medical training (Balmer et al., 2017; Moir et al., 2018). Online interviews also removed geographical barriers, enabling participation from students across the UK and ensuring that those who commuted long distances or lived at home were not disadvantaged.

This online approach also offered methodological advantages. Research on digital interviews suggests that remote settings can reduce power imbalances and enhance participants' sense of control, particularly for those who might feel marginalised in institutional settings (Grey et al., 2020). Several participants appeared more comfortable discussing sensitive topics, such as accent bias, financial insecurity, and feelings of exclusion, in familiar environments, such as their homes. This aligns with feminist and class-sensitive research, which emphasises creating interview spaces that minimise intimidation and promote participants' agency (Skeggs, 1997; Reay, 2017).

Interviews lasted between 45 and 90 minutes, depending on participants' availability and the depth of discussion. The interview schedule (Appendix 2) provided a guiding framework but was used flexibly, allowing conversations to follow participants' priorities and emotional cues. This was particularly important when discussing experiences of misrecognition, symbolic violence, or family tensions, as participants sometimes needed time to reflect or pause. The interviews' relational approach fostered richer, more nuanced, and emotionally complex accounts than those from the survey, revealing how class shaped students' identities, relationships, and professional goals.

Overall, the interview phase was essential to the study's methodological and analytical richness. It created a relational, dialogic, and ethically sensitive space, crucial for exploring the complexities of classed experiences in medical education, dimensions that the survey alone could not fully capture.

Analytical Process

Reflexive thematic analysis was chosen as the method because it aligns with the study's interpretivist and critical sociological principles. Unlike more structured or coding-focused approaches, RTA views meaning as socially constructed, context-dependent, and shaped by power dynamics, an essential perspective for exploring class experiences, symbolic violence, and belonging within elite institutions such as medical education (Braun & Clarke, 2006; 2019; Burawoy, 2019). Its flexibility allows both semantic and latent analysis, capturing participants' explicit statements as well as the deeper structural inequalities that inform them (Reay, 2017; Loveday, 2015). RTA emphasises the researcher's reflexive role in interpreting meaning, which is especially important given the researcher's partial insider status and the topic's emotional and cultural complexity (Skeggs, 1997; Jagger & Fry, 2023). This approach thus facilitates a theoretically grounded, detailed, and ethically sensitive examination of the lived experiences of working-class medical students.

The analytic process started with immersing in the data. Interviews were transcribed word-for-word, and survey responses were compiled into a single dataset. Repeated readings helped shape initial impressions of belonging, misrecognition, precarity, and identity. These readings also fostered reflexive awareness, especially when shared classed experiences created emotional resonance (Coyle et al., 2021; Reay, 2004). Coding was performed manually and inductively, drawing on Bourdieusian concepts and Yosso's Community Cultural Wealth framework. Codes aimed to capture participants' explicit descriptions and the structural and symbolic processes influencing them (Bourdieu, 1986; Yosso, 2005). Examples included 'feeling out of place', 'accent comments', 'commuting limits belonging', 'family pride and pressure', 'hidden costs', and 'navigating middle-class norms'. These codes highlighted the relational, affective, and structural aspects of classed experiences expressed by participants, aligning with broader research on class navigation in higher education and professional settings (Bathmaker et al., 2018; Beagan, 2005; Bullock, 2016).

As coding progressed, patterns of meaning emerged across the dataset. Rather than treating themes as fixed categories, they were developed iteratively, moving between coded extracts, the full dataset, and the theoretical framework (Miles & Huberman, 1994). Some early clusters were collapsed due to conceptual overlap, while others were expanded to reflect the depth and frequency with which participants described them. Material precarity, for example, emerged as a distinct theme because it recurred across interviews and surveys, shaping students' access to placements, social spaces, and informal learning opportunities. This pattern is consistent with research on classed constraints in medical education (Nicholson & Cleland, 2017; Latham et al., 2025). Other themes, such as belonging and identity work, were refined to capture the emotional and symbolic labour involved in navigating middle-class institutional norms (Skeggs & Loveday, 2012; Jagger, 2025).

The final themes were selected not for their frequency but for their analytical importance and their capacity to illuminate the structural and cultural factors shaping working-class students' experiences. This approach aligns with the principles of reflexive thematic analysis, which prioritise meaning, patterns, and interpretation over representativeness (Braun & Clarke, 2019). Consequently, these themes serve as interpretive narratives grounded in participants' accounts yet shaped by the researcher's theoretical perspective and reflexive process. They

structure the discussion chapters, each examined in detail and linked to broader sociological debates on class, inequality, and professional identity (Reay, 2015; Skeggs, 1997; Bathmaker et al., 2018).

Ethical Considerations

Informed consent is a foundational principle of ethical research, particularly when engaging with participants from marginalised or underrepresented groups. In this study, informed consent was treated not as a one-off procedural requirement but as an ongoing ethical relationship between the researcher and participants (British Sociological Association, 2024). Given the sensitive nature of the research, which explored class, identity, and exclusion within elite educational and professional spaces, it was essential to ensure that participants fully understood the purpose, scope, and potential emotional implications of their involvement (Reay, 2017; Skeggs, 1997; Gillies, 2005).

Participants received a detailed information sheet outlining the study's aims, the voluntary nature of participation, and their right to withdraw at any time up to the write-up stage without penalty. This aligns with ethical guidance that consent must be 'freely given, informed and ongoing' (BSA, 2024). Consent was obtained electronically for both the online survey and the semi-structured interviews, and participants were given opportunities to ask questions before and after their involvement. This approach was particularly important given the power dynamics inherent in research on social class, where participants may feel pressure to comply or be unfamiliar with academic research processes (Gillies, 2005; Reay, 2015; Soria and Bultmann, 2014). The use of digital consent forms also demonstrated a commitment to accessibility and participant autonomy. As Braun et al. (2020) observe, online qualitative research can empower participants by enabling them to engage on their own terms, in familiar settings, and at times that suit their schedules. This was particularly important for medical students, whose time is often constrained by clinical placements and academic commitments (Balmer et al., 2017; Moir et al., 2018; Klassen and Klassen, 2018).

All data was anonymised during transcription to protect participants' anonymity and confidentiality. Pseudonyms were used in all written outputs, and any identifying details, such as specific institutions, locations, or personal anecdotes, were removed or altered to protect identities. Audio recordings were stored securely on encrypted, password-protected devices and deleted after transcription. In line with data protection regulations, only the researcher had access to the raw data, and all files were handled in accordance with institutional data management policies (British Sociological Association, 2024).

Given the potential for emotional distress, especially when discussing experiences of exclusion, financial hardship, or family responsibilities, care was taken to establish a supportive, non-judgemental environment during interviews. Participants were reminded that they could pause or end the interview at any time without giving a reason. After the interviews, a list of support services, including university counselling, student wellbeing teams, and external mental health resources, was provided to all participants. This was particularly important given the emotionally charged nature of the topics covered, which could evoke feelings of shame, frustration, or vulnerability (Reay, 2015; Loveday, 2015; Shields, 2023; Crew, 2025).

Recognising the time pressures faced by medical students, especially during the COVID-19 pandemic, interviews were scheduled around participants' availability and conducted online

via secure platforms such as Zoom or Teams. Accessibility and flexibility also remained important ethical considerations. This approach reduced the burden of participation and enabled students with caregiving duties, limited mobility, or financial constraints to participate (Kettell, 2020; Braun et al., 2020).

In summary, ethical practice in this study went beyond merely following procedures to include building a relationship of trust and care. By prioritising participant wellbeing, safeguarding confidentiality, and maintaining transparency throughout the research process, this study sought to uphold the highest standards of ethical integrity in sociological research.

Reflexivity and Researcher Positionality

Reflexive practice was crucial to the design and execution of this research, particularly given the shared social positioning between the researcher and the participants. As a working-class academic exploring the experiences of working-class medical students, the researcher occupied a dual position, both insider and outsider, situated within the academic environment yet shaped by a background that resonated with many of the challenges described by participants. This duality required ongoing critical reflection on how the researcher's assumptions, values, and emotional responses influenced the research process. As Reay (2015) and Skeggs (1997) argue, researchers must remain aware of how their social positioning affects not only the questions they ask but also how they interpret and portray others' voices. This aligns with Bourdieu's (1990) call for epistemic reflexivity, in which researchers examine their habitus and the power dynamics embedded within the research field (Wiegmann, 2017). To support this, the researcher kept a reflexive journal throughout the interview process, documenting decisions, dilemmas, and emotional responses during data collection and analysis.

This approach ensured the analysis remained grounded in participants' narratives while acknowledging the interpretive lens through which those narratives were understood (Cunningham et al., 2018; Cribb and Bignold, 1999). Reflexivity also played a vital ethical role in managing the power dynamics inherent in qualitative research. While sharing a class background can help build rapport and trust, it also risks over-identification or the assumption of commonality where differences exist (Coyle et al., 2021; Loveday, 2015). For instance, although the researcher recognised many of the institutional barriers described by participants, care was taken not to equate their experiences with personal ones. Instead, each narrative was approached with openness and curiosity, allowing participants to define their own meanings and priorities.

This approach aligns with the British Sociological Association's (2024) emphasis on respect, dignity, and participant autonomy, and reflects the ethical imperatives outlined by Beagan (2005) for researching marginalised groups in medical education. Reflexivity extended into the analysis phase, during which the researcher continually questioned how theoretical commitments, particularly to Bourdieu's concepts of habitus and symbolic violence, shaped the coding and interpretation of data (Atkinson, 2011; Halewood, 2023). The researcher also remained attentive to moments when participants' narratives revealed tensions between their embodied dispositions and institutional expectations, especially when these tensions led to internal conflicts or misalignment.

By embedding reflexivity throughout the research process, the study sought to produce findings that were not only analytically rigorous but also ethically and emotionally attuned to

the lived realities of those whose stories it sought to honour. As Shields (2023) and Rickett and Morris (2020) suggest, such reflexive engagement is particularly vital when working-class researchers navigate the emotional labour of representing their communities in academic spaces.

Although the recruitment method effectively assembled a diverse and talented group of working-class medical students, it is essential to recognise its limitations. The cohort comprises individuals who chose to participate and were able to do so, so it does not fully represent all working-class students in UK medical schools. This study seeks an analytical understanding rather than a statistical generalisation. The results highlight patterns within this group that reflect broader structural processes, while acknowledging that class experiences vary by context, identity, and institution.

Discussion Chapter 1. Crossing Boundaries – Working–class Lives - Middle-class Profession.

This chapter will examine participants' experiences as they navigate the education system and further explore how working-class medical students experience and manage their sense of self within the university. Drawing on Bourdieu's (1977, 1990) concepts of habitus and symbolic violence, and Skeggs' (1997, 2004) work on respectability and moral value, it explores how students navigate the tension between their home identities and the expectations of elite professional spaces. For many, university is the first time they become acutely aware of their class position, not as an abstract category but as a lived, often painful dissonance between belonging and exclusion (Reay, 2017).

Through students' voices, this chapter explores how class identity is performed, challenged, and redefined in everyday interactions with peers, staff, and institutional norms. It examines how pride, loyalty, and the burden of representation influence students' experiences, and how the emotional labour of 'fitting in' often comes at the expense of authenticity, while critically examining the psychosocial costs of upward mobility and the limits of inclusion in spaces that continue to privilege middle-class norms.

Bourdieu's (1977) concept of habitus, when applied to working-class medical students, offers a valuable lens for understanding their unique challenges and experiences within the medical field. Working-class medical students must quickly adapt to both the alien environment of the university and the unspoken rules and an unfamiliar language. Additionally, during their studies, they must find a place to fit within the clinical environment and learn the formal and informal expectations, which are often complicated by the formal curriculum and the hidden curriculum. Students who are the first in their families to attend university are especially reliant upon university staff to help them transition into the unfamiliar territory.

However, many higher education institutions are founded on very conservative ideas that things have always been a certain way, tried and tested, and therefore, are reluctant to change (Reay, 2015). The 'institutional habitus' includes the culture, academic and social practices, and assumptions about students at universities, which can influence the student experience and educators' attitudes and expectations towards students. All these factors can make working-class students feel like 'outsiders on the inside' (Reay, 2015:117). Where

universities expect all students to be prepared for the transition through schooling and familial connections, many students who need extra support often remain unnoticed.

The illusion of a ‘classless environment’ (Hanley, 2017:12) stems from the belief that merely being granted access to an elite space is sufficient to surmount the entrenched, structural barriers within the English higher education system. These structural barriers exist within the university. Importantly, those who develop inclusion initiatives for working-class students often focus solely on the economic barriers they face. While these interventions should be welcomed, they can overlook the cultural and structural barriers that also need to be addressed.

Consequently, students enrolled in an elite programme, such as medicine, face additional complexities. Many medical students have a familial connection to the profession and therefore have insight into the expectations of medical school and the pathways to success (references). Those without familial connections to medicine must quickly learn expectations and unfamiliar language to create a professional pathway from their medical degree (Friedman and Laurison, 2020). Universities can be a complicated field to navigate for those who, through their lived experience, have not encountered the rules of engagement for elite institutions or an elite training programme.

Similarly, the decision to widen participation to make university an option for students from all backgrounds has created complexity. As elite institutions and programmes such as medicine have consistently made attempts to be more inclusive, there remains a dearth of evidence to show that, indeed, rather than inclusion and opportunity for all, there are significant misunderstandings of what constitutes the modern student, particularly concerning social class (Friedman and Laurison, 2020; Social Mobility Commission, 2016; Reay, 2019).

Class background significantly influences habitus, affecting individuals’ attitudes, behaviours, and expectations. Additionally, interactions with institutions—such as schools, the NHS, and the criminal justice system- further shape this concept, often positioning working-class individuals as recipients of services rather than as contributors (Bhatti, 2003; Prideaux, 2010). Education plays a crucial role in developing the habitus of young people. In contrast, simultaneously, the marketisation of education has exacerbated inequalities, with the quality of a child’s school, their neighbourhood, and the occupations of their primary caregivers critically determining the opportunities available to them (Reay, 2015; Hanley, 2019). This process of stratification that continues to pervade British society is underplayed, and a myth continues that opportunities are available to all. Despite the cultural significance of meritocratic ideas, the Social Mobility Commission (2016; 2024) consistently finds that inequality in the UK is increasing and that opportunities to progress are limited for those born into working-class families.

Despite the silence surrounding classed identity over recent decades, which, according to hooks, has unwittingly supported class elitism (2000:163), more working-class students are attending university and overcoming the barriers to success. In a stubbornly elite field, these students entering university to study medicine face further obstacles in the recruitment process. The recruitment process for medical students is highly competitive. Applicants must demonstrate their qualifications through predicted A-level grades, successful interviews, and completion of the University Clinical Aptitude Test (UKCAT) to secure a place. Despite navigating ingrained inequality to succeed in the process of earning a place at medical

school, many working-class medical students find the culture and unspoken rules difficult, which in turn can hamper their sense of belonging (BMA, 2015, 2019).

In the university context, institutional habitus refers to how the embedded culture, norms, values, and practices of an institution shape the experiences and expectations of those within it (Reay et al, 2001). It is not merely about the formal curriculum or policies but rather the unspoken assumptions and cultural codes that govern behaviour and belonging. For working-class students, entering a space where middle-class norms dominate can be disorienting and alienating. The subtle privilege of specific ways of speaking, dressing, or interacting can signal to these students that they are outsiders. As Reay (2015:115) observes, 'there is shame in both belonging and escape, shame in escape because it is about betrayal and desertion'. This duality captures the emotional complexity of social mobility, where success often entails a painful distancing from one's roots.

Moreover, working-class identity is often associated with a sense of inferiority, not because of any inherent deficiency, but because of how societal structures devalue certain forms of knowledge and experience (Skeggs and Loveday, 2015). Reay (2015) extends Bourdieu's concept of habitus to explore how the pressure to adapt to unfamiliar environments can affect individuals on a psychosocial level. The internal conflict between maintaining authenticity and conforming to institutional expectations can lead to what Bourdieu (1990) terms cleft habitus, a dissonance between one's ingrained dispositions and the demands of a new social field. For working-class medical students, this dissonance is particularly acute, as they must navigate both the middle-class-dominated university environment and the highly stratified hierarchical culture of the medical profession.

Access to top professions often hinges on securing relevant work experience or internships, which can be particularly challenging for working-class students due to financial constraints or a lack of social capital. Medicine is no exception. Shadowing doctors, volunteering in clinical settings, or attending preparatory courses often necessitate unpaid time, travel, and insider knowledge, resources that are unevenly distributed (BMA, 2024). In addition to excelling academically within a socially stratified education system, working-class students who lack access to medical professionals to facilitate this experience must instead draw upon their 'navigational capital' (Yosso, 2005) and seek alternative ways of gaining experience in caring for people. This structural disadvantage is compounded by the fact that admissions processes reward these experiences, thereby reinforcing existing inequalities.

Early Educational Experiences

From the earliest stages of formal education, working-class children face systemic disadvantages that go beyond material deprivation. These include underfunded schools, larger class sizes, and limited access to enriching activities that promote cognitive and social development (Sutton Trust, 2018). However, the disadvantage is not solely structural; it is also deeply psychosocial. The education system, as Bourdieu (1986) argues, privileges the cultural capital of the middle class, embedding norms, values, and behaviours that marginalise working-class students.

This marginalisation is not always obvious. It often occurs through what is known as the hidden curriculum, which relates to the implicit lessons about behaviour, values, and expectations that are not explicitly taught but remain central to the educational experience (Tomlinson, 2005; Ball, 2003; Gilbert, 2018). In schools, the hidden curriculum reinforces

middle-class norms, such as individualism and competitiveness. These norms are internalised through daily practices: how students are disciplined, how success is defined, and how teachers interact with pupils (Boronski and Hassan, 2015; Reay, 2015).

For working-class students, the hidden curriculum can act as a form of symbolic violence (Bourdieu, 1991), subtly conveying that their ways of speaking, behaving, and knowing are inferior. This can lead to a gradual loss of confidence and a sense of not belonging. The emotional and psychological toll of this cultural mismatch is profound, shaping not only academic outcomes but also students' sense of self and their perceived place in the world (Gilbert, 2018).

Josie, a second-year medical student, articulates this experience with striking clarity:

> I think that I am beginning to understand that 'our' schools are there to churn out good employees who do as they are told. Private schools create confidence/entitlement. 'We begin university as less than and can feel it; getting into university is not enough to bridge that gap (Josie, Year 2).

Josie's reflection captures the emotional burden of class stratification. Her words reveal a deep understanding of how educational institutions are designed to reinforce social hierarchies. The contrast she draws between state and private education reflects the broader ideological function of schooling, as described by Boronski and Hassan (2015), who argue that education is not a neutral space but one that is ideologically constructed to reflect and reproduce dominant norms. Gilbert (2018) supports this view, noting that working-class students are often viewed through a deficit framework, in which their cultural and social backgrounds are seen as lacking rather than assets. This framing is not only damaging to self-perception but also sustains institutional biases that favour middle-class norms. The result is a form of internalised oppression, where students begin to question their legitimacy within academic spaces.

The emotional and psychological toll of this process is significant. Reay (2005) describes how students must navigate feelings of inadequacy, alienation, and imposter syndrome to succeed in environments that were not designed for them. These emotional burdens are often invisible to educators and policymakers, yet they influence students' engagement, confidence, and long-term outcomes. Conversely, middle-class students often experience education as a space of affirmation. Their home environments align with school expectations, and they are socialised into norms of academic success from an early age. They start school with a sense of entitlement and confidence that is continually reinforced by their interactions with teachers, peers, and the curriculum (Ball, 2003). This alignment between home and school creates a seamless educational journey, where success feels natural and expected.

Despite these structural and psychosocial barriers, many working-class students show remarkable determination, adaptability, and strategic agency. Yosso's (2005) concept of navigational capital offers a solid framework for understanding how students from marginalised backgrounds develop the ability to manoeuvre through institutions that were not built with them in mind.

Students who achieve excellent A-level results and gain places in competitive courses like medicine do so not because the system supports them but often despite it. Their achievements show a sophisticated ability to interpret institutional expectations, manage

conflicting demands, and persist despite exclusionary practices. These students are not simply surviving the system; they are actively negotiating it, often relying on community knowledge, peer support, and a strong sense of purpose. This kind of capital is not solely individual but often rooted in collective experiences and intergenerational knowledge. It reflects a strategic navigation cultivated through shared experiences of marginalisation and perseverance (Reay, 2006; 2017). As such, it challenges deficit narratives that portray working-class students as lacking and instead highlights the intellectual and emotional resources they bring to educational spaces.

Josie's story exemplifies this strength. Her awareness of the systemic inequalities within the education system and her ability to articulate their emotional impact demonstrate a critical consciousness that itself acts as a form of capital. Her journey to medical school, despite the barriers she recognises, proves her capacity to navigate and resist the system. Recognising navigational capital also has important implications for widening participation initiatives. Instead of focusing solely on access, these initiatives must also value the cultural wealth students bring. This involves rethinking admissions policies, offering culturally responsive support, and creating institutional cultures that affirm rather than assimilate diverse identities. As Yosso (2005) argues, educational equity requires not only removing barriers but also recognising and validating the strengths marginalised students already possess.

In this context, the achievements of working-class students should not be viewed as exceptional or unexpected. Instead, they should be seen as evidence of the systemic inequalities they have overcome and the sophisticated strategies they have developed in response. Their successes are not anomalies; they are demonstrations of what is possible when students are supported, valued, and encouraged to thrive on their own terms.

Thinking About a Medical Career - The Cost of Aspiration: Class, Meritocracy, and the Limits of Widening Participation

The participants in this study all met the criteria for widening participation, with working-class backgrounds being a key characteristic. They attended state schools, were first-generation university applicants, lived in areas with low participation in higher education, or were mature students. Policies aimed at improving access to higher education often identify working-class students as a central focus for inclusion efforts (Finnegan and Merrill, 2017). This chapter examines how these working-class students experienced the aspiration to study medicine, exploring their motivations, decision-making processes, and the barriers they faced. Their narratives reveal how classed experiences shaped their educational journeys, highlighting the emotional, cultural, and material labour needed to pursue a profession often viewed as elite and inaccessible to those from non-traditional backgrounds.

The Sutton Trust's report Unequal Treatment (Latham et al. 2025) highlights persistent class-based disparities in gaining access to medical education and careers. Students from socioeconomically disadvantaged backgrounds and non-selective state schools continue to encounter disproportionately high barriers, as shown by national application and admission trends. Between 2012 and 2022, applications to medical schools in England increased by 64 per cent. However, admissions grew by only 44 per cent (Latham et al. 2025: 4). While applications from non-selective state schools have risen, students from independent schools, whose numbers have remained steady, still secure a disproportionate share of offers. This imbalance is not merely a reflection of academic merit but is influenced by

unequal access to tailored guidance, interview coaching, and institutional support (Friedman and Laurison, 2020; Boursicot and Roberts, 2009).

These advantages extend beyond academic preparation into the cultural and social domains. Bourdieu's (1986) concept of cultural capital refers to the knowledge, behaviours, and communication styles that are valued by institutions and often unconsciously rewarded. Middle-class students are more likely to possess these traits, which align with the expectations of elite universities and professional pathways. Ball et al. (2002) describe how students' choices about higher education are shaped by their access to information, confidence, and networks, as well as resources that are unevenly distributed along class lines. These patterns of familiarity with institutional norms reinforce a cycle in which privilege reproduces itself, sustaining access to elite professions and limiting class diversity in medicine.

To address these disparities, widening participation policies have been widely adopted across the higher education sector. These initiatives, described by Boronski and Hassan (2016: 227) as an 'interventionalist strategy that has blurred the lines of exclusion and elitism', aim to increase access for underrepresented groups, particularly those from lower socioeconomic backgrounds. However, as Reay (2017) and Bathmaker et al. (2018) caution, these policies often operate within a meritocratic framework that obscures the structural inequalities they aim to address. The dominant narrative suggests that talent and hard work are sufficient for success, yet this overlooks the uneven starting points from which students begin their educational journeys.

The framing of widening participation within a meritocratic and neoliberal discourse, which emphasises individual responsibility and employability, risks depoliticising class inequality (Livesey, 2019). As O'Shea and May (2017) argue, university education is now widely seen as essential for full participation in post-industrial society and for contributing to national economic success. However, this instrumental view of education often overlooks the emotional and cultural labour required of working-class students to adapt to middle-class academic environments. For many of these students when realisation of the need to fit sets in it can leave create a when the realisation of the need to fit in sets in, it can create a sense of dislocation, as described by Loveday (2015) and Reay (2015) who both highlight how working-class students frequently experience feelings of shame, inadequacy, and dislocation as they attempt to conform to institutional norms that do not reflect their own lived experiences.

Moreover, the emphasis on aspiration and resilience within widening participation discourse can inadvertently place the burden of adaptation on the individual rather than address the systemic barriers embedded in educational institutions. This is particularly problematic in medicine, where the entry pathways are tightly regulated and culturally coded. As Michalec (2011) and Balmer et al. (2017) note, the hidden curriculum in medical education, the unspoken norms, values, and expectations, often privileges those who already possess the social and cultural capital to navigate these spaces with ease.

The belief in meritocracy, while appealing, can also be psychologically damaging for those who fail. McCoy et al. (2013) suggest that while meritocratic beliefs may offer a sense of control and motivation, they can also lead to internalised blame when structural disadvantages are misinterpreted as personal failure. This is especially relevant in medicine, where the stakes are high and the competition intense. Students from working-class

backgrounds may find themselves questioning their place in the profession, not because of a lack of ability, but because of the cumulative impact of exclusionary practices and a lack of cultural alignment with institutional expectations.

Furthermore, the symbolic power of elite institutions plays a significant role in shaping who feels entitled to belong to a particular group. Bourdieu (1994) describes symbolic capital as the intangible assets, such as confidence, accent, and mannerisms, that signal legitimacy and status. Students from privileged backgrounds often enter medical school with a sense of entitlement and ease, while their working-class peers must work harder to prove their legitimacy. This dynamic is reinforced by what Reay et al. (2009: 1103) describe as the 'stranger in paradise' effect, where working-class students in elite universities feel like outsiders, constantly negotiating their identity and worth. Despite the rhetoric of inclusion, the structural framework of medical education continues to favour those who already possess the resources to succeed. As Savage et al. (2025) argue, class-based exclusion is upheld through mechanisms of closure and symbolic domination, which limit the transformative potential of widening participation. Soria and Bultmann (2014) similarly note that institutional cultures often fail to provide the necessary support for working-class students to thrive, even when access is granted. Nicholson and Cleland (2017) further emphasise the importance of social capital, access to networks, mentors, and informal knowledge as a key determinant of success in medical education.

A 2025 study published in The BMJ examined the widening participation and contextual admissions criteria used by UK medical schools and found significant inconsistencies across institutions. While most schools consider indicators such as free school meal eligibility, care experience, or postcode-based deprivation indices, the criteria are applied unevenly. This lack of standardisation creates confusion and inequity, as an applicant who qualifies for contextual consideration at one university may not qualify at another. The study calls for a coordinated national framework to ensure fairness and transparency in medical school admissions (Greenhalgh et al, 2015). Similarly, data from the Sutton Trust (2025) reveal a persistent underrepresentation of working-class students in medical education, despite their academic achievements. This challenges the notion that higher education is a level playing field. As Markovits argues, 'merit itself is not a genuine excellence but rather… a pretence constructed to rationalise an unjust distribution of advantage’(2009, xxi). In this view, meritocracy becomes a legitimising myth, one that masks inequality by attributing outcomes to individual effort rather than systemic privilege. A meritocratic approach to widening participation, therefore, risks reinforcing the very hierarchies it seeks to dismantle.

Nevertheless, one significant benefit of the belief in meritocracy is that it helps sustain the perception that individuals have personal agency over their future outcomes. This belief can foster a sense of motivation and responsibility, as people are more likely to attribute success or failure to their efforts, talents, and decisions rather than to external factors such as social class or systemic inequality. As McCoy (2013) suggests, this perception of control can be psychologically empowering, encouraging individuals to strive for achievement and persevere through challenges, even in the face of structural barriers. For many working-class students, this belief provides a source of hope and direction, even if it does not fully reflect the realities of structural inequality.

Thus, while meritocracy may mask systemic disadvantages, it simultaneously offers a framework through which individuals can find purpose, tenacity, and hope in their

educational and professional experiences. The challenge for policymakers and educators is to reconcile these competing dimensions, acknowledging the motivational power of meritocratic ideals while addressing the deep-rooted inequalities that continue to shape access to medicine and other elite professions.

Given this context, it is unsurprising that many participants approached the application process for medical education with hesitation. Despite demonstrating strong motivation, their aspirations were often accompanied by uncertainty and self-doubt. This ambivalence reflects the broader tensions faced by working-class students as they navigate elite educational spaces. While the belief that hard work leads to success remains a core value in neoliberal societies, and participants in this study took pride in their work ethic, this belief was often challenged by the structural realities they encountered during the application process. As Krstic et al suggest, working-class students recognise that they are competing in 'a system in which they are disadvantaged, feeling that they have to work harder to compensate' (2012:6). The narratives of the participants in this study suggest that although meritocratic ideals were personally motivating, they were not always sufficient to overcome the psychological and material barriers embedded in applying for medicine.

While gaining admission to medical school is often celebrated in policy discourse as a hallmark of upward social mobility, this framing did not resonate with most participants in this study. For many working-class students, the notion of social mobility as a conscious goal felt abstract, disconnected from their lived realities, and at times even alienating. Rather than viewing their entry into medicine as a symbolic escape from their class background, participants spoke more often in terms of gratitude, responsibility, and a desire to give back to their communities. Education research (Willis, 1977; Reay, 2008, 2015; Hanley, 2019) evidence the paradoxes that many working-class people face when they encounter education and the potential for moving socially upward in terms of employment, it is not the risk of academic failure that is at the forefront of their mind but the risk of losing the safety and unfamiliarity of their community in exchange for the unknown.

This contrast between policy rhetoric and personal motivation is significant. Government and institutional narratives often portray medicine as a prestigious and transformative career path, one that enables individuals to enhance their socio-economic standing and transcend their class origins. However, such narratives often overlook the emotional and cultural complexities that accompany class transitions. Reay (2017) argues that working-class students often experience mixed feelings about upward mobility, as it can evoke feelings of guilt, loss, and disconnection from their communities and families. These emotional tensions are not merely incidental but are embedded in the very process of social mobility, which can be experienced as both an opportunity and a disruption. For many students, the act of moving into a different social class is not simply a matter of personal achievement but a complex negotiation of identity, belonging, and loyalty. This contrast was reflected in the accounts of several participants in this study, who expressed a strong sense of pride in their working-class backgrounds and a marked reluctance to frame their academic and professional achievements as a departure from those origins. Rather than viewing their entry into medicine as an escape from the past, they described it as a continuation of the values instilled in them by their families and communities, including hard work, resilience, and a commitment to helping others. In this way, their narratives challenge the dominant discourse of social mobility, offering a more grounded and relational understanding of aspiration and success (Bourdieu, 1986; Reay, 2017) instead.

Instead of aspiring to status or prestige, participants in this study were more likely to articulate motivations that were grounded in practical, immediate concerns. These included the desire for financial stability, long-term job security, and the opportunity to contribute meaningfully to society. Such motivations reflect a pragmatic orientation toward the future, shaped by the economic precarity and structural inequalities that many working-class students have experienced throughout their lives. Rather than being driven by abstract ideals of success or social elevation, their decisions were guided by a need for security and a desire to make a positive difference in others' lives.

> I needed a stable job. For me, a university had to offer a good wage and provide opportunities to help people. Growing up, I had little in terms of ‘stuff, but I had supportive parents who wanted me to do well. I suppose this made me realise the importance of earning ‘enough’, but also the importance of people. Luckily, I got the A levels I needed and was able to study medicine (Meg, year 4).

This finding is consistent with the work of Ingram (2023), who argues that working-class students often prioritise stability and community impact over symbolic markers of prestige or class advancement. Ingram’s research highlights how these students tend to view education and career choices through the lens of practical necessity and social responsibility, rather than as a means of distancing themselves from their backgrounds. Similarly, participants in this study described medicine not as a ladder to climb, but as a stable and socially valuable profession that would allow them to support their families, contribute to their communities, and live with a sense of purpose and dignity (Finnegan and Merrill, 2020).

The emphasis on relational support was also a central theme in participants’ narratives. Many spoke with deep appreciation for the encouragement and guidance they received from parents, teachers, and mentors. These relationships were not merely instrumental in helping them access higher education but were also emotionally sustaining throughout their academic journeys. Participants frequently described their parents as hardworking, self-sacrificing individuals who instilled in them a strong work ethic and a sense of moral responsibility. Their success in gaining a place at medical school was often framed not as an individual triumph, but as a collective achievement that honoured the sacrifices and support of those around them.

This emphasis on relationality challenges the individualistic assumptions embedded in dominant social mobility discourses, which tend to valorise personal ambition, self-determination, and meritocratic ideals. As Ingram (2023) notes, working-class students often resist these narratives, instead framing their aspirations in terms of care, reciprocity, and social contribution. In this context, success is not about rising above others, but about lifting others and remaining connected to their communities and values. The participants’ stories reflect a more communal and grounded understanding of aspiration, one that is deeply embedded in their social and familial networks (Yosso, 2005).

Moreover, the idea that entering medicine made participants better than they were before was explicitly rejected by many. Such a framing was perceived as not only inaccurate but also disrespectful to their families and communities. For these students, the suggestion that they had escaped their background implied a devaluation of their origins, which conflicted with their sense of identity and loyalty. Rather than viewing their educational success as a break from the past, participants described it as a continuation of the values and strengths

they had inherited from their upbringing. This included resourcefulness, empathy, and a strong work ethic, qualities they believed were essential to their success in medicine.

This resistance to dominant narratives of social mobility underscores the importance of recognising class not merely as an economic category but as a deeply embedded cultural and emotional identity. Attridge (2021) and Savage (2015) both highlight how working-class students in elite educational settings often experience cultural dissonance, in which their identities are not fully recognised or valued within the dominant institutional culture. This dissonance can manifest as alienation, imposter syndrome, or a sense of being caught between two worlds. Participants in this study echoed these sentiments, describing moments of discomfort and disconnection in academic environments that often assumed middle-class norms and values as the default.

Friedman and Laurison (2020) further argue that even when working-class individuals gain access to elite professions, they often face a class ceiling that limits their progression and recognition. This ceiling is not only structural, but also cultural, as it reflects the subtle ways in which dominant norms and expectations marginalise those from less privileged backgrounds. Similarly, Calarco (2020) emphasises that middle-class advantage is often reproduced through institutional practices that reward familiarity with dominant cultural codes, leaving working-class students to navigate unfamiliar, often exclusionary systems.

These findings suggest that widening participation initiatives in medicine and in higher education more broadly must move beyond simplistic narratives of social mobility. While access to elite professions can indeed open new opportunities, it is crucial to acknowledge the emotional labour and cultural negotiation involved in such transitions. For working-class students, success is not always experienced as liberation or elevation; it can also entail loss, conflict, and a persistent sense of in-betweenness. The process of navigating new social and professional spaces often requires students to adjust or downplay aspects of their identity, which can be both psychologically taxing and ethically troubling.

In this context, it becomes essential for institutions to develop more inclusive and responsive support systems that recognise the diverse experiences and motivations of students from underrepresented backgrounds. Rather than if all students aspire to move up the social ladder in conventional terms, universities and medical schools should create spaces where alternative aspirations, such as community service, social justice, and relational success, are equally valued and supported. This requires a more nuanced understanding of aspiration, one that is attentive to context, identity, and the relational dimensions of educational journeys (Bourdieu, 1986; Yosso, 2005).

The experiences of many working-class medical students challenge dominant narratives of social mobility by foregrounding alternative values and motivations. Their stories reveal a complex interplay between pride in their origins, gratitude for support, and a commitment to social contribution. By listening to these voices, we can begin to reimagine what success looks like in higher education, not as a departure from their roots, but as a continuation of them in new and transformative ways.

Understanding student motivation is crucial, as it influences how individuals engage with learning and impacts academic outcomes (Moir, 2018). The participants expressed a range of motivations for pursuing a career in medical education, shaped by their personal experiences, values, and the challenges they had encountered. A recurring theme was the

desire for security. Much like traditional working-class trades, medicine was perceived as a stable, respected profession, offering long-term financial and occupational security. For some, the decision to pursue a career in medicine was also influenced by personal or familial experiences with illness, which instilled a sense of purpose and a desire to give back to others.

Nevertheless, only five participants expressed confidence in their decision to pursue a career in medical education. For the majority, self-doubt was a persistent feature of their experience. This lack of confidence was not necessarily a reflection of academic ability, but rather a product of their social positioning. Many questioned whether they truly belonged in such a competitive and exclusive field. These doubts were often internalised, shaped by a lifetime of subtle messages about who medicine is for. Encouragement from supportive teachers, mentors, and family members played a crucial role in countering these feelings. In several cases, a single teacher's belief in a student's potential was the catalyst for applying to medical school.

This interplay between motivation and self-doubt highlights the significance of relational support in shaping educational trajectories. It also emphasises the limitations of individual effort when confronted with systemic inequality. While participants in this study display high motivation and a willingness to work hard, their success in applying for medical education often depended on access to encouragement, information, and advocacy, resources that are unevenly distributed across social class lines.

> I loved science and thought I should try to make it into a career. My A-levels were stressful because I doubted whether I could get into medical school. Luckily, my mum and my teachers were encouraging, and I achieved the grades that I needed' (Rosie, Year 2).

Although class was not explicitly discussed at this stage, the internalised effects of class position were evident. Working-class students often lack a sense of entitlement or belief in their right to succeed (Gilbert, 2018; Reay, 2019). This is where Bourdieu's concept of habitus becomes particularly useful. Habitus refers to the deeply ingrained dispositions, perceptions, and behaviours shaped by one's social background. It influences how individuals perceive their place in the world and what they believe is possible for them. For many working-class students, a habitus shaped by limited opportunities and constrained choices can lead to self-censorship, in which certain careers, such as medicine, feel out of reach even when academic ability is present (Willis, 1977; Bourdieu, 1996; Reay, 2003).

Entering unfamiliar and elite spaces requires significant determination. As Willis (1977) observed, many working-class individuals may 'self-eliminate' (1977:86) or opt out of such pathways, instead choosing roles where they feel a sense of familiarity and acceptance. This is not a reflection of a lack of ambition, but rather a rational response to structural barriers and a lifetime of social conditioning (Willis, 1977; Reay, 2015). In contrast, students from families with a history of professional careers, especially in medicine, tend to exhibit greater self-assurance. Their habitus is aligned with the expectations of elite institutions, making them more comfortable navigating the cultural codes of higher education. Bourdieu's concept of 'symbolic mastery' (1994:156) complements this, explaining how those socialised into dominant cultural norms more easily adopt the language, behaviours, and expectations that signal belonging, rather than thoughts of not being good enough to pursue elite careers, many harbour the belief that they have the right to be there. 'Symbolic mastery' is a

performance of confidence, not a performance of competence. As Reay suggests, the natural taken-for-granted brightness of the middle-classes also need to be challenged, and particularly the assumption that it is natural and intrinsic rather than carefully constructed and intentionally constructed from birth' (2017:441)

Efforts to widen participation in medicine have made some progress (Greenhalgh et al, 2004; Brosnan and Turner, 2009). Joe, a third-year student, highlights the potential of targeted outreach:

> I had never really considered medicine as an option for me. We had a careers event at school, and we were lucky to have a doctor visit. When I listened to the different specialisms and choices available, I thought I should at least try (Joe, Year 3).

Joe's use of the word 'lucky' is telling. It reflects the rarity of such exposure in his educational environment, highlighting the uneven distribution of social capital. For Joe, within his network, the only doctors he had seen were those at a clinic when seeking health care. For students from more privileged backgrounds, access to professionals, especially in medicine, is often embedded in their networks, making such encounters routine rather than exceptional (Friedman and Laurison, 20; Greenhalgh et al., 2015). Joe's school, by contrast, lacked these embedded connections, making the doctor's visit a rare and valuable moment of insight.

Joe's habitus, shaped by unfamiliarity with elite professions, did not initially include medicine as an option. The careers event disrupted this internalised framework, temporarily expanding his sense of possibilities. However, his response, 'I thought I should at least try', still carries a tone of caution. This hesitancy reflects the fragility of aspiration among working-class students, whose belief in their potential is often shaped by limited exposure and systemic barriers (Hanley, 2019; Latham, 2025).

Lucy (year 2) similarly described herself as 'lucky' to have had a teacher who encouraged her to apply. This shared language of luck is not incidental; it reveals a more profound truth about the poverty of opportunity in under-resourced educational settings. For Lucy, as for Joe, the encouragement to pursue a career in medicine was not embedded in the school culture but came through a chance encounter with a supportive individual. In more privileged contexts, such guidance is often institutionalised and expected. For working-class students, it is experienced as a fortunate exception.

This language of luck also reflects a lack of entitlement, a recurring theme of working-class habitus. Unlike their middle-class peers, who may feel a natural sense of belonging in elite spaces, students like Joe and Lucy often approach such spaces with humility and uncertainty. Saying 'I was lucky' can be a way of downplaying one's merit or deflecting attention from the structural barriers that were overcome. It also signals an awareness that others in similar positions may not have had the same chance.

Programmes like the British Medical Association's Aspiring Doctors initiative aim to address these disparities by offering mentorship, financial support, and application guidance to students from underrepresented backgrounds (BMA, 2023). However, Joe's and Lucy's experiences underscore that such interventions are still not universally accessible. Their sense of luck points to the randomness of opportunity in under-resourced schools, where a single event or individual can significantly alter a student's trajectory.

For students whose habitus includes a clear and familiar trajectory from school to university and into professional careers, success feels both attainable and expected. For others, particularly those from working-class backgrounds, it remains a tentative hope, one that must be actively nurtured through sustained support, meaningful exposure, and structural change. The participants in this study demonstrate that working-class students possess the intellectual capacity to achieve the highest academic standards and the determination to pursue professional careers. However, what they often lack, and cannot be easily taught in school, is the sense of entitlement required to navigate elite spaces and to recognise their worth within them confidently. These lessons are learned through the experience of navigating an unequal social world.

Aspiration is often considered a failing of the working classes in societies considered as meritocratic (Gilbert, 2018; Reay, 2019; Hanley, 2019). Markovits (2019) argues that meritocracy, intended to reward individuals based on their talents and efforts, is a fabricated concept. It rationalises and perpetuates existing inequalities by presenting them as fair and deserved. He also emphasises the psychological and emotional burdens of meritocracy, noting that the relentless pursuit of success and the constant pressure to prove one's worth can result in anxiety, stress, and a sense of inauthenticity among those striving to meet its demands (Markovits, 2019).

As Reay suggests, ‘a meritocratic system is a competition in which there are clear winners and losers, but in which the resulting inequalities are justified on the basis that participants have an equal opportunity to prove themselves’ (2017:122). Notions of meritocracy often overlook the unequal life experiences of individuals and instead perpetuate the myth that hard work alone guarantees success (Friedman and Laurison, 2019). A meritocratic approach to widening participation suggests that students from non-traditional backgrounds may have deficiencies that can be addressed through taster experiences and additional support, thereby instilling in them the values and attributes deemed desirable (Krstic et al, 2021). Thus, while outreach programmes can indeed be beneficial for some students, helping them see different opportunities, as in Joe’s case, these programmes are not designed to be equitable and therefore adaptable to differing experiences. Instead, they aim to share the expectations that persist in elite programmes that applicants must adhere to.

Classed Pathways through the Hidden Curriculum of Medical Admissions.

The hidden curriculum, those unspoken norms, values, and expectations embedded within educational systems, begins long before students set foot in a university lecture hall. This research found that the hidden curriculum extends from the application process through to clinical training, profoundly shaping the experiences of working-class applicants. For these students, applying to medicine involves more than academic preparation; it requires navigating a complex and often inaccessible system that demands not only intellectual effort but also considerable emotional labour. This includes managing stress, concealing financial hardship, and projecting confidence in environments that may feel unfamiliar or even exclusionary (Cribb and Bignold, 1999; Clark, Mountford-Zimdars and Francis, 2015; BMA, 2024).

Participants described the UCAT (University Clinical Aptitude Test) as an early and significant source of both financial and emotional strain. Although the test costs £70, its

symbolic weight far exceeds its monetary value. It represents the beginning of a series of structural barriers that disproportionately affect working-class applicants. Pete, a second-year student, recalled:

> There is only my mum and I at home. I worked during my A levels to help. However, we could not afford to pay for the UCAT. I applied for a bursary and waited for six weeks to find out that I was successful. It was stressful.

Pete's experience illustrates the emotional toll of financial precarity, in which even the first step towards a medical career is fraught with uncertainty. Although bursaries are available, the application process itself introduces delays and anxiety, reinforcing a sense of instability and exclusion. As Balmer et al. (2017) argue, the admissions process often assumes a baseline of financial and cultural capital that many working-class students lack. Critics have noted that the UCAT is implicitly aligned with the educational experiences of privately educated students, who are more likely to receive targeted preparation and institutional support (Sutton Trust, 2025; Boursicot and Roberts, 2009). Conversely, students from state schools in deprived areas often lack access to such resources. While online training exists, it is frequently fee-based, further privileging those with financial means. This creates a dilemma for working-class applicants: either invest in a test for which they are underprepared or risk being excluded from the profession altogether.

This situation exemplifies what Bhatti (2003: 67) describes as being 'caught in the interface of policy and practice'. On paper, widening participation policies seem inclusive, offering bursaries and contextual admissions. In practice, however, they often fail to consider the lived realities of applicants who must navigate unfamiliar institutional cultures and expectations. The UCAT thus becomes a gatekeeping mechanism, not only academically, but also culturally and economically. As Loveday and Skeggs (2012: 480) observe, the struggle for working-class students is not limited to securing financial stability. It also involves 'pretending that everything was 'ok', when worry, guilt and shame shaped their lives'. This emotional strain is a defining feature of the hidden curriculum. It reflects the pressure to conform to middle-class norms of composure and self-assurance, even when the reality is one of precarity and marginalisation. The need to appear confident and capable, despite limited access to resources or support, places an additional psychological burden on students who are already navigating a highly competitive and unfamiliar admissions process (Greenhalgh, Seyan and Boynton, 2004; Finnegan and Merrill, 2017).

This burden is compounded by the expectation that students must demonstrate resilience and self-sufficiency, qualities often celebrated in meritocratic discourse yet rarely supported in practice. The belief that hard work alone guarantees success can be a powerful motivator, but it also obscures the structural inequalities that shape educational trajectories. As Gilbert (2018) and hooks (2014) argue, recognising that a career is possible and believing that one belongs in that career are essential to fostering aspiration. However, for many working-class students, this belief is fragile, constantly undermined by systemic barriers, cultural misrecognition, and a lack of institutional support.

In this context, the UCAT becomes more than a test of aptitude. It symbolises the broader challenges faced by working-class students in accessing elite professions. It reveals how financial, cultural, and emotional capital are unequally distributed, and how policies intended to promote inclusion can inadvertently reinforce exclusion. Addressing these issues requires more than financial aid or outreach initiatives. It demands a critical re-evaluation of the

assumptions embedded in admissions processes, and a commitment to recognising the diverse forms of capital that working-class students bring to medicine.

Whether through outreach programmes, UCAT preparation support, or bursary guidance, institutions must recognise that working-class applicants are often more dependent on the system, more vulnerable to its inconsistencies, and more attuned to its signals. Their success depends not only on their effort but on how effectively institutions acknowledge and respond to the structural disadvantages they face. The inconsistency of the support available means that some applicants do not receive support. Unlike Joe, who received encouragement from university outreach teams. Comparatively, Sophie always knew she wanted to pursue a career in medicine. Rather than being uplifted, Sophie was advised to lower her aspirations. As she recalls:

> I was advised to consider nursing at school. I was told it would be more financially accessible for me and that I would be able to pick up shifts in a care home to support my studies (Year 3 student).

This experience illustrates how working-class individuals are often socially positioned in specific roles throughout their lives (Reay, 2019). This is not to suggest that working-class students lack ambition. Rather, as Ball (2013: 127) argues, ‘our understanding of ourselves is linked to ways in which we are governed’. In Sophie’s case, the advice she received was not neutral; it reflected a broader system of lowered expectations, in which she was implicitly told to ‘know her place’.

Nevertheless, Sophie resisted this narrative. Her persistence reflects a frequently overlooked strength within working-class communities, the capacity to navigate complex systems and solve problems with limited resources. This form of resilience is not merely about individual determination, but about drawing upon practical knowledge, emotional intelligence, and social awareness developed through lived experience. It represents a form of agency that operates within, and often against, structural constraints.

This stands in contrast to what Bourdieu (1994: 156) describes as ‘symbolic mastery’, the internalised ability to perform the cultural codes of the dominant class, such as how to speak, dress, and behave in ways that signal competence and belonging. For many middle-class students, this mastery is cultivated from birth and aligns with institutional expectations. However, it is often more symbolic than substantive. Sophie’s actions, by contrast, represent actual mastery, not the performance of belonging, but the practice of breaking barriers without the benefit of inherited privilege or established networks.

Her persistence also challenges dominant constructions of excellence. It reminds us that what is often celebrated as excellence is not a neutral or universally agreed-upon standard. Institutions tend to define excellence in ways that reflect and reinforce existing power structures, privileging cultural norms, behaviours, and credentials. As Razack et al. (2018: 50) argue, ‘we must develop the habit of critiquing how excellence is being constructed and how such notions might constrain our appreciation of diverse forms of excellence’. Without this critical lens, we risk overlooking the talents, contributions, and potential of individuals whose strengths may not align with conventional metrics, but who nonetheless bring valuable perspectives and capabilities to their fields.

Sophie’s story, and those of other participants, can be understood through Yosso’s (2005) concept of navigational capital, which refers to the ability to manoeuvre through social

institutions that were not designed with marginalised groups in mind. This form of capital is not about assimilation, but about persistence, adaptation, and resistance in the face of systemic barriers. For working-class students, navigating the medical school admissions process, including high-stakes testing, financial constraints, and cultural unfamiliarity, requires precisely this kind of capital. It is a resource rooted in lived experience, often invisible to institutional gatekeepers, yet essential for survival and success in elite educational spaces.

This tension between aspiration and constraint was evident in the reflections of several participants. As part of their decision to pursue medicine, many expressed a clear awareness of the risks associated with higher education. Rising tuition fees, increasing living costs, and growing competition in graduate employment markets have made the university pathway feel less secure and more uncertain (Friedman and Laurison, 2020; Clark et al, 2015). For working-class students, the decision to attend university is rarely framed as a journey of self-discovery. Instead, it is often a calculated risk, based on 'the promise of improved employability through HE' (O'Shea and May, 2017:75) and the need for financial stability and long-term security.

The developing precarity of the Medical Profession.

The narratives in this study reveal that many participants chose medical training to mitigate some of the risks associated with investing in a university education, thereby securing long-term stability.

> My main motivation to apply to medicine was my sister; she was born with a lifelong condition and has had both good and poor treatment. I studied hard to become one of the good doctors. I know first-hand what a difference good care makes to the whole family. I also thought medicine was a good career choice with a guaranteed job at the end of the training. I know many people who have degrees but have not managed to find a graduate job, and for me, if I had not managed to get into medicine, I would not have taken the risk of attending university (Chantal, year 2).

Historically, the medical profession has been associated with 'expected autonomy, deference and respect (Laverty et al, 2024: 809). However, the rise of neoliberal ideologies within the UK's welfare state has transformed this once-stable career into one characterised by precarity, short-term contracts, and increasing managerial control. Within the Sociology of Work, scholars have highlighted 'how increased insecurity, mobility and intensity of work' (Laverty et al, 2024: 810) have reshaped perceptions of the NHS, evolving from a model employer to one now marked by instability and reduced job security. Participants in this study often lacked personal connections to the medical profession, beyond those encountered in clinical settings or through targeted outreach initiatives. Consequently, during both the application process and the early stages of medical school, they remained unaware of the profession's growing instability and the erosion of its traditional status. As Laverty et al. (2024: 818) note, the role of the doctor is increasingly 'treated as a commodity for the current needs of the organisation rather than for their benefit as the next generation of doctors'. In 2025, becoming a doctor in the UK no longer guarantees a lifelong career, nor the professional security it once did.

Nevertheless, for many working-class students who are unaware of these systemic shifts, the aspiration to enter medicine remains driven by a hope for long-term stability and social

mobility. The disconnect between expectation and reality carries significant implications. As Friedman and Laurison (2020) argue, medicine has long been perceived as a reliable route to upward mobility. However, the current landscape tells a different story. According to the BMJ (2024), newly qualified doctors are increasingly struggling to secure permanent employment, with many being placed on reserve lists due to a lack of available posts. This growing mismatch between medical training and employment opportunities reflects broader failures in workforce planning and investment, raising critical questions about the profession's sustainability and the promises it continues to make to aspiring students. For working-class applicants, this perception aligns with their broader aspirations for long-term security.

However, this instrumental approach to higher education can also limit access to the wider cultural and social opportunities that universities offer, such as extracurricular involvement or international study, which are often more accessible to middle-class peers (Reay, 2019). These students must not only compensate for having less economic capital but also invest their time wisely to build a professional network they previously lacked access to and to cultivate the many opportunities that academic success requires for a meaningful career. As such, the decision to pursue medicine is shaped not only by ambition but also by a careful calculation of risk, reward, and the structural constraints of class.

Bourdieu’s (1991) concept of symbolic violence helps explain how structural inequalities are internalised and normalised within professional fields, such as medicine. Resident doctors may come to accept long hours, unpaid overtime, and poor working conditions as the norm, or even as deserved, particularly when they lack the cultural capital to question institutional norms. For working-class doctors, this internalisation is compounded by deeply ingrained values of hard work, resourcefulness, and self-reliance, which are often celebrated within working-class communities (Skeggs, 1997; Reay, 2019). While a source of pride, these values can also make it harder to recognise exploitation or challenge unfair treatment, as enduring hardship is seen as expected. As a result, working-class doctors may feel pressure to prove themselves through overwork, reinforcing feelings of inadequacy and exclusion when their efforts are not recognised or rewarded.

Moreover, the ideology of meritocracy, often promoted as a fair system where success is based on talent and effort, can obscure these structural disadvantages. As Markovits (2019) and Reay (2017) argue, meritocracy tends to reward those who already possess the social and cultural capital to succeed, while blaming those who struggle for their own lack of progress. For working-class students, the belief in meritocracy can lead to internalised guilt and self-doubt when the promised rewards of hard work, such as job security and professional respect, fail to materialise. This contradiction is particularly stark in medicine, where the profession’s elite image persists despite the growing evidence of its declining material and emotional rewards (BMA 2023; 2024).

In this context, the perception of medicine as an elite and secure profession is increasingly at odds with the lived experiences of those entering the field. While students from wealthier families may be shielded from the worst effects, thanks to financial support and familial connections, working-class students are more vulnerable to the profession’s shifting realities. Their reliance on medicine as a route to stability may, paradoxically, place them in a more precarious position.

Alternative entry routes

Access to Medicine programmes aim to address educational inequalities by providing alternative pathways into medical education for students with lower A-level grades and for mature applicants (British Medical Association, 2015). These initiatives seek to make the medical profession more reflective of the society it serves. However, despite progress in gender and ethnic diversity, working-class communities remain persistently underrepresented (Greenhalgh, Seyan and Boynton, 2004). Programmes such as The Right Mix and Aspiring Doctors attempt to redress this imbalance by supporting young people from lower socioeconomic backgrounds. While these initiatives promote social justice, they often struggle to challenge entrenched perceptions of class-based aspirations and deficit thinking, the belief that working-class students inherently lack the skills, motivation, or cultural capital needed to succeed in medicine (Greenhalgh et al, 2004).

Despite the limitations of widening participation efforts, alternative entry routes were crucial for several participants in this study. These routes provided a lifeline for individuals whose life circumstances did not align with traditional academic trajectories. Zena, a third-year medical student, reflects:

> Although I would not change caring for my mum, there was nobody else; the additional pressures throughout my A levels meant that although Science was always my best subject, I did not achieve the grades needed for university. I had to take time out before attending university. I used the time working in adult care to strengthen my application, then applied for an access-to-medicine course (Zena, Year 3).

Similarly, Leon, a mature third-year student, shares:

> I did not have the opportunity to study A levels when I left school more than 20 years ago. Nobody that I knew from my school studied at university. I had worked as a healthcare assistant in my local doctor's surgery and wanted to do more to support patients. The GP I worked for encouraged me to apply for an Access to Medicine course, which boosted my confidence.

Although neither Zena nor Leon explicitly references class or educational inequality, their narratives reveal the structural barriers they faced. For both, there was no clear ‘rite of passage’ to university (Friedman and Laurison, 2020:26). Their experiences reflect a lack of institutional habitus, the alignment between their social background and the expectations of higher education. Leon grew up in an environment where university was not considered a viable option, while Zena had to balance caregiving responsibilities with academic aspirations. Both chose to work in the care sector before applying to medical school, an experience that, although valuable, also reflects the necessity of navigating a more labour-intensive path to meet application requirements.

The Medical Schools Council (2018) recommends that applicants gain experience observing doctors in clinical settings. However, this ideal is often only accessible to those with the necessary social and cultural capital to secure such opportunities. Applicants like Zena must instead forge their own paths, frequently through paid roles in care settings. While these roles are legitimate, they are typically more available to those who need to earn an income to support their studies, underscoring the impact of economic capital on access. In contrast, applicants with familial ties to medicine or financial backing are more likely to obtain unpaid clinical placements through established networks (Friedman and Laurison, 2020). Although

the Medical Schools Council acknowledges that work experience may be gained in either a paid or voluntary capacity, this flexibility does not account for the unequal access to time, money, and connections that influence these choices.

One overlooked aspect of working-class identity is the resourcefulness required to succeed in unfamiliar and often exclusionary environments. This resourcefulness can be understood as embodied cultural capital, the internalised knowledge, dispositions, and competencies acquired through lived experience and socialisation, rather than through formal education or inherited privilege (Bourdieu, 1986). These embodied traits are often neither recognised nor valued within institutional settings; yet they are crucial for navigating the complex demands of medical education.

Understanding the application process and securing relevant paid experience requires considerable effort, often without the guidance or support that more privileged applicants take for granted. As O'Shea and May note, 'support is not readily available to the many students who may lack the time, confidence, and the sense of entitlement to ask for help' (2014: 210). Participants in this study exhibited strength and resourcefulness in seeking support, whether from an employer, a parent, or a teacher. However, this support, while meaningful, does not equal the advantage conferred by having someone in one's network who has navigated medical education themselves.

Consequently, such programmes must not only provide access but also address the structural and cultural barriers that continue to define who is viewed as a suitable candidate for medical education. However, gaining access is merely the beginning. Students entering medicine through these alternative pathways often face additional stigma and challenges to their sense of self. Their experiences within medical school are shaped by the dominant norms and values of the educational field, a concept Bourdieu (1990) describes as a structured social space governed by specific rules, expectations, and hierarchies. Within this field, traditional forms of capital, such as elite schooling, A-level qualifications, and shared cultural experiences, are frequently privileged, while alternative routes and backgrounds are often devalued. This is evident in the experiences of some students who entered university through a widening access route.

Jack, a student who progressed from a foundation year, reflects on this dissonance:

> Last year, I was on a foundation year in medicine. I enjoyed the course and felt like I did well academically. Joining year one has made me question my decision to study medicine; I stand out. While my classmates are discussing their travels across Asia, I commute in. One person asked me, 'What do you drive?' Nothing, mate. I get the bus. I cannot afford insurance. When you cannot find shared interests, you just get shut out of the conversations (Jack, year 1).

Jack's experience illustrates how symbolic violence, Bourdieu's term for the subtle, often invisible ways in which dominant cultural norms are imposed and internalised, operates within the field of medical education (Bourdieu, 1991). His lack of shared cultural capital, including travel experiences or car ownership, sets him apart. These minor social cues reinforce a sense of exclusion and inferiority, even in the context of strong academic performance.

Leon, a mature student in his third year, echoes this sentiment:

> At the beginning of uni, people were discussing their school experiences and results. As a mature student, I did an access course. Not only am I older and stand out, but I feel like they look down on me because I don't have A-levels. (Leon, year 3).

Leon's reflection highlights how symbolic hierarchies within the field continue to privilege traditional educational pathways. Despite his success and commitment, his alternative route is perceived as less legitimate. This reinforces the symbolic violence experienced by students who do not conform to the dominant norms of the field, leading to feelings of marginalisation and self-doubt.

Together, these narratives underscore the need for Access to Medicine programs to widen entry and transform the institutional culture of medical education. Without addressing the symbolic structures defining who belongs, such initiatives risk reproducing the inequalities they aim to dismantle.

The entry process.

Regardless of the year of entry, significant barriers persist in accessing medical training. Admissions processes often favour applicants who align with what Vincent (in Bourdieu, Passeron et al.) describes as 'the type of education which symbolises membership of the elite' (1994:09). This reflects a broader process of social reproduction, in which access to prestigious professions is mediated by cultural capital, often unconsciously recognised and rewarded by university gatekeepers. Bourdieu's concept of 'symbolic mastery' (1990: 56) highlights how individuals who can perform the expected cultural and linguistic codes are more likely to enter elite spaces, such as medicine and law (Reay, 2017; Bathmaker et al., 2018). These codes are not neutral but classed, raced, and gendered, privileging those already embedded within dominant social structures (Friedman and Laurison, 2020).

In contrast, working-class applicants, often disconnected from the social networks that facilitate the accumulation and exchange of valuable forms of capital, are, as Skeggs and Loveday argue, frequently positioned as culturally deficient and 'misrecognised as valueless' (2012: 483). This misrecognition is the process by which dominant cultural norms are accepted as legitimate, even by those they marginalise. It reinforces symbolic hierarchies and has material consequences, shaping perceptions of who is a legitimate candidate for medicine and who is systematically excluded (Skeggs and Loveday, 2012; Reay, 2015).

Nevertheless, the unfamiliarity of elite spaces to many working-class students does not equate to a lack of aspiration. Their decision to pursue a career in medicine is an act of ambition and a testament to their belief in meritocratic ideals. However, the admissions process often reflects a socially constructed and biased vision of what a doctor looks like, one that implicitly favours middle-class norms such as polished interview performance, extracurricular travel, or unpaid work experience, all of which are less accessible to those from working-class backgrounds (Becker, 1977; Latham, 2025).

Despite these structural barriers, interviews revealed a consistent theme of resourcefulness and determination among working-class applicants. As the literature confirms, even with the necessary grades and determination to train to be a doctor, there are multiple barriers that hamper entry into medical programmes.

This chapter has explored the complex and often contradictory realities that working-class students face in accessing and navigating medical education. While widening participation

initiatives have opened doors, they have not dismantled the deeper institutional and cultural barriers that shape who feels entitled to belong and who must continually justify their presence.

The hidden curriculum, those unspoken norms and expectations embedded in elite educational spaces, plays a powerful role in shaping student experience. Participants like Josie described the emotional burden of entering university as less than', highlighting how access alone does not bridge the cultural and psychological gap between working-class students and middle-class academic environments.

Financial precarity also plays a significant role. Pete's account of struggling to afford the UCAT, despite working during his A-levels, underscores how structural barriers begin even before admission. Similarly, Sophie was advised to lower her aspirations and consider nursing instead of medicine, reflecting how institutional actors can reinforce classed expectations under the guise of practical advice. However, these students also demonstrate remarkable strategic adaptability and determination. Joe, who first considered medicine after a rare school visit from a doctor, and Rosie, who overcame self-doubt with the support of her mother and teachers, exemplify how working-class students often rely on chance encounters and relational support to access elite pathways. Their use of words like 'lucky' reveals how opportunity is often experienced as a fortunate exception rather than a rite of passage.

Consequently, we must be cautious not to idealise the success of working-class students in medicine. While their achievements are often framed as inspirational, this framing can obscure the structural inequalities they have had to overcome and the emotional toll of navigating elite spaces. Celebrating their determination without acknowledging the systemic barriers they face risks reinforcing a narrative that success is simply a matter of individual effort. As the chapter illustrates, students like Pete and Sophie struggled not because the system supported them, but often despite it. Their stories reflect not just personal triumphs, but also the failures of institutions to provide equitable support.

Framing these students as 'resilient' can also place undue pressure on them to perform gratitude and perseverance, even when they are struggling. It can silence the very real experiences of alienation, fatigue, and self-doubt that many face. Josie's reflection reminds us that access does not equal belonging, and that success often comes at a personal cost, one that is invisible in celebratory narratives. This is particularly evident in the experience of imposter syndrome, which is often mischaracterised as an individual psychological flaw. It is a socially constructed response to exclusion and misrecognition. For many working-class students, feelings of not belonging are not irrational, but entirely logical reactions to environments that fail to reflect their identities, values, or lived experiences. Imposter syndrome, in this context, is not a personal failing, but a symptom of institutional cultures that privilege certain forms of knowledge, behaviour, and confidence while marginalising others.

Moreover, idealising success can shift responsibility away from institutions and onto individuals, implying that those who fail lacked the will or ability. It reinforces meritocratic myths that obscure the role of class, culture, and capital in shaping educational outcomes. Instead of viewing these students as exceptional anomalies, we must recognise their success as evidence of what is possible when structural barriers are challenged—and as a call to action for institutions to do more to support, affirm, and include students from all backgrounds.

The notion of medicine as a stable and prestigious profession has long underpinned its appeal, particularly for working-class students seeking long-term security and social mobility. However, this perception is increasingly at odds with the evolving realities of the profession. The rise of short-term contracts increased managerial oversight, and workforce shortages have contributed to a growing sense of precarity within the medical field. The promise of stability is no longer guaranteed. For working-class students, who often enter medicine with the hope of escaping economic insecurity, the erosion of job stability and the intensification of work can be particularly disillusioning. Unlike their middle-class peers, who may have familial support or professional networks to buffer against uncertainty, these students are more vulnerable to the consequences of an unstable labour market.

Moreover, many working-class students enter medical education without a full understanding of the profession's changing realities. Unlike their middle-class peers, they often lack access to informal networks or mentors who can offer candid, either encouraging or cautionary, insights into the evolving nature of medical careers. Without these sources of guidance, students may pursue a career in medicine, believing it guarantees long-term security, unaware of the growing uncertainty within the profession. This lack of informed advice means their decisions are often made in isolation, based on hope rather than reliable information. Consequently, the emotional and financial investment in medicine can become a source of anxiety when the expected outcomes, such as job stability, progression, or professional autonomy, fail to materialise.

The mismatch between medicine's symbolic prestige and its material realities creates a tension that disproportionately affects those who have the most to lose. As the chapter shows, this precarity is not only economic but also psychological, compounding pressure, self-doubt, and the constant need to prove one is worth. In this context, the belief in medicine as a secure career must be critically re-evaluated. Institutions have a responsibility to be transparent about the realities of the profession and to support students not only in gaining access but also in navigating the shifting terrain of medical work. This includes addressing the structural conditions that produce precarity and ensuring that the promise of medicine as a pathway to stability does not become another myth that working-class students must unlearn.

To move beyond symbolic inclusion, medical education must critically examine its practices and assumptions. This includes rethinking admissions criteria, standardising contextual offers, and embedding culturally responsive support throughout the student journey. It also requires a shift in institutional culture, one that values diverse forms of excellence, recognises the emotional labour of class transition, and affirms the identities and aspirations of all students.

Discussion Chapter 2. Who Do I Think I Am? – Navigating Relationships at Home and with University/Medical Peers

The previous chapter explored how working-class students navigate the structural and cultural barriers embedded in the application process and early stages of medical education. It highlighted how class-based inequalities persist despite widening participation initiatives and how students often rely on navigational capital (Yosso, 2005) and relational support to

access elite programmes such as medicine. However, gaining entry is only the beginning. Once inside the institution, students must negotiate a new set of challenges, ones that are not only academic but deeply personal and emotional.

This chapter shifts the focus from access to identity, examining how working-class medical students experience and manage their sense of self in university and clinical settings. Many participants in this study combined full-time medical education with caring responsibilities or long commutes, conditions that intensified the emotional labour required to sustain academic performance while conforming to middle-class norms of professionalism. Drawing on Bourdieu's (1977, 1990) concepts of habitus and symbolic violence, and on Skeggs' (1997, 2004) work on respectability and moral value, it explores how students navigate the tension between their home identities and the expectations of elite professional spaces. For many, university is the first time they become acutely aware of their class position—not as an abstract category, but as a lived, often painful dissonance between belonging and exclusion (Reay, 2017).

Through students' voices, this chapter explores how class identity is performed, challenged, and redefined in everyday interactions with peers, staff, and institutional norms. It considers how pride, loyalty, and the burden of representation shape students' experiences, and how the emotional labour of 'fitting in' often comes at the cost of authenticity. In doing so, it builds on the themes of aspiration and resilience introduced in Chapter 1, while critically examining the psychosocial costs of upward mobility and the limits of inclusion in spaces that continue to privilege middle-class norms.

Despite the challenges, many participants expressed pride in their working-class identity. Zena's statement, I am proud of my working-class background; it makes me appreciate the small things, reflects a form of resistance to dominant narratives that equate success with assimilation into middle-class norms. This pride is not merely symbolic; it is a form of cultural wealth, rooted in resilience, community, and lived experience.

Developing Class-Consciousness

Accessing higher education is frequently framed as a transformative milestone, one that promises social mobility, personal growth, and professional advancement. However, for working-class students, particularly those entering elite and traditionally middle-class professions such as medicine, this transition is not solely academic; it is a deeply social and emotional confrontation with entrenched class hierarchies. These students often arrive at university with a strong belief in meritocracy and the value of hard work, a belief shaped by familial and educational environments that emphasise individual effort (Reay, 2005; McCoy et al, 2013). Yet, upon entering university, they encounter peers whose educational journeys have been eased by access to private tutoring, cultural familiarity with institutional norms, and social networks that facilitate belonging, advantages that are often invisible to those who possess them but starkly apparent to those who do not (Bathmaker et al, 2018; Friedman and Laurison, 2020).

This chapter examines how working-class medical students come to recognise their class position not as a fixed label but as a lived, evolving identity. Drawing on participant narratives and sociological theory, it shows how class consciousness develops through contrast, comparison, and emotional labour. The university, far from being a neutral or universally accessible space, becomes a site of insight, where the hidden structures of

privilege are revealed, and students begin to critically question the fairness of the systems they have worked so hard to enter (Reay, 2017; Loveday, 2015; Lehmann, 2014).

Many participants in this study reported that they did not recognise their working-class background as a disadvantage until they entered university. This delayed realisation of class difference is a significant theme in their stories and reflects broader sociological insights into how class functions as an often unseen but deeply structuring force.

Louise, a third-year medical student, articulates this moment of realisation:

> It is so difficult not to compare lives when I know I am in the minority. However, despite the now-obvious disadvantage, I didn't realise I was at a disadvantage until I got to university. I just thought everyone had to work hard to get into med school, and they do, but some harder than others. I achieved the highest A-levels possible. I faced many challenges growing up working-class, around poverty. This made me resilient, independent, and driven to pursue a more financially stable life for myself.

Louise's narrative exposes how meritocratic values are internalised, suggesting success is due to personal effort rather than systemic advantages. This belief, often reinforced through schooling and family stories, can obscure the systemic barriers that influence educational access and achievement. Her realisation upon entering university signifies a vital shift in understanding, a recognition that although all students may put in effort, the conditions under which they do so are unequal (Reay, 2017).

Joe, a third-year medical student, reflects:

> I am proud of my working-class background; it makes me appreciate the small things, and it also makes me who I am. Although it was not something I was really aware of before I met people at uni.

Joe's narrative offers a powerful insight into the affective and relational dimensions of class consciousness. His pride in his background is not framed as a barrier to overcome, but as a source of identity and value. This pride, however, is not innate; it emerges through contrast, through the process of encountering others whose lives and assumptions differ markedly from his own. His statement, *'it was not something I was really aware of before I met people at uni',* reflects the relational awakening that many working-class students experience when they enter middle-class institutional spaces (Reay, 2017).

The appreciation for 'the small things' reflects what Yosso (2005) calls resistant and familial capital, the cultural knowledge and values developed within working-class communities that are often ignored or undervalued in academic settings. These include humility, gratitude, and a strong sense of connectedness, which contrast with the individualism and entitlement sometimes linked to middle-class norms (Skeggs, 1997). Joe's pride is therefore not merely personal; it is political. It challenges deficit narratives that depict working-class students as lacking and instead highlights the richness of working-class culture as a legitimate and valuable foundation for academic and professional life.

Furthermore, Joe's delayed realisation of his class identity aligns with Bourdieu's (1986) concept of habitus, the internalised dispositions shaped by one's social environment. Growing up in a working-class setting, Joe's experiences were normalised; it was only through exposure to his peers' cultural capital that his position became apparent. This

moment of realisation is not merely cognitive; it is emotional, often accompanied by discomfort and a growing sense of critical awareness (Reay, 2005; Loveday, 2015).

Joe's story also marks the beginning of what Reay (2015) calls a reflexive habitus, the capacity to reflect on one's social position and navigate conflicts between institutional norms and personal identity. His pride is not naive; it's grounded in an awareness of difference and a refusal to be diminished by it. Thus, Joe's experience illustrates how class consciousness develops as an active, relational process, fuelled by emotion, comparison, and resistance.

Zena, another third-year student, reflects on the moment her identity became visible in a new and complex way:

> 'Before I came to uni, I was just Zena, now I am a female, BAME, working-class medical students'.

Zena's statement powerfully captures the process of identity fragmentation and reclassification that often occurs when students from marginalised backgrounds enter elite academic spaces. Her words reflect a shift from a unified sense of self to one that is categorised and made hyper-visible through institutional and social lenses. This transformation is not self-generated but rather imposed through contrast, as it involves the experience of being positioned as 'other' to dominant norms of whiteness, maleness, and middle-classness that often underpin university culture (Reay, 2017; Skeggs, 1997).

Her reflection aligns with Reay's (2001:49) assertion that 'identity is about difference and difference generates exclusion'. Zena's experience illustrates how the university, while often framed as a meritocratic and inclusive space, can function as a site of symbolic boundary-making (Bourdieu and Passeron, 1994). The categories she lists, female, BAME, and working-class, are not neutral descriptors but markers of social location that carry with them histories of marginalisation and exclusion. These identities become significant not because Zena has changed, but because the institutional environment renders them visible in ways that are often alienating.

This process is intensified by the widening participation (WP) agenda, which, while aimed at increasing access, often fails to address the deeper cultural and structural inequalities embedded within higher education (Bathmaker et al, 2018; Coyle et al, 2021). WP initiatives tend to focus on numerical inclusion, getting more students from underrepresented backgrounds through the door, without transforming the institutional cultures that continue to privilege middle-class norms. As a result, students like Zena may gain access but still feel out of place, constantly reminded of their difference through subtle cues, social interactions, and institutional practices.

The norm of comparison, as Zena implies, is not neutral. It is shaped by the experiences of students who have benefited from private education, parental support, and familiarity with academic life. These students often arrive at university already fluent in the language of success, confident in seminars, comfortable with self-promotion, and equipped with the social capital that facilitates belonging (Ball et al, 2002; Friedman and Laurison, 2020). In contrast, students from working-class and racially minoritised backgrounds must often learn to navigate these norms while simultaneously managing the emotional labour of being visibly different.

Yosso's (2005) concept of community cultural wealth offers a critical counterpoint to deficit narratives that frame students like Zena as lacking. Her pride in her working-class background, *'it makes me appreciate the small things, and it also makes me who I am'*, reflects aspirational, familial, and resistant capital. These forms of capital are cultivated through lived experience and are often undervalued by institutions that equate success with middle-class dispositions. Zena's ability to reflect critically on her identity and to assert pride in her background is not a sign of deficiency but of resilience and reflexivity.

Her narrative also speaks to the intersectionality of identity. She is not just working-class, or BAME, or female, she is all of these at once, and the interplay of these identities shapes her experience in complex ways. As Hill Collins (2009) and Crenshaw (1991) argue, intersectionality is essential to understanding how systems of power operate. Zena's experience cannot be reduced to a single axis of identity; it must be understood in relation to the overlapping structures of race, class, and gender that shape her position within the university.

In this way, Zena's reflection is both personal and political. It reveals the emotional and cognitive work required to make sense of one's identity in a space that often fails to recognise or value it. It also highlights the limitations of inclusion policies that fail to address the cultural and epistemic exclusions that persist in higher education. Her narrative challenges us to rethink what it means to belong, and to consider how institutions might move beyond access to create spaces where all forms of capital are recognised and valued.

Chantal, a second-year student, provides a vivid account of her upbringing:

> I certainly come from a working-class background; I live in a council house with my mother. She worked part-time as a shop assistant/cleaner while I was growing up. Most of my family haven't gone to university and still live within a few miles of where they grew up, this is very typical of where I am from.

Chantal's narrative illustrates how class is woven into the fabric of everyday life, shaped by geography, family history, and local social norms. Her account reflects what Reay (2006) describes as the situated nature of class identity, how one's sense of self is formed through long-standing ties to place, community, and shared experience. The continuity of residence, occupation, and educational trajectories within her family underscores the intergenerational transmission of classed expectations (Willis, 1997; MacDonald et al, 2020). While these localised attachments can foster strong social bonds and emotional resilience, what Yosso (2005) terms familial capital, they can also make the transition to university feel like entering a foreign cultural landscape.

This sense of cultural dislocation is not experienced in isolation but is often accompanied by a strong desire to remain connected to one's roots. For many students, the university is not a space of reinvention but of negotiation—where they must learn to inhabit two worlds without abandoning either. Ted, another second-year student, articulates this tension between institutional affiliation and personal identity:

> People at home have normal jobs. When I go home, I can go to the pub and speak about football or play five-a-side. Studying medicine does not change who I am or what I like.

Ted's account builds on Chantal's by highlighting the everyday practices through which working-class students maintain continuity with their communities. His narrative challenges the assumption that higher education inevitably leads to cultural transformation. Instead, it reveals the ongoing negotiation of identity across social contexts, the familiar, grounded culture of home and the unfamiliar, often alienating norms of the university. Rather than resolving this tension through assimilation, Ted maintains a dual orientation: he participates in the medical profession while remaining rooted in the cultural practices and values of his upbringing.

At the outset of their decision to apply to medicine, neither Chantal nor Ted was motivated by a desire to transcend or disown their class background. Instead, they sought a career that offered security, stability, and a meaningful way to contribute, often framed as 'paying back' the support and sacrifices of their families. None of the participants in this study aspired to become 'better than' their background. They simply wanted to become doctors and worked hard against systems of exclusion to reach that goal. This motivation challenges dominant narratives of social mobility that frame success as escape or transformation. For these students, success is not about following a tribe to become like everyone else; it is about leading themselves with pride into a secure future in a meaningful role.

Both Chantal and Ted exemplify identity preservation, a conscious effort to retain their working-class values and ways of being in the face of institutional pressures to conform. Their stories reveal that success, for many working-class students, is not about becoming someone else but about remaining true to who they are. This is a powerful form of resistance, one that redefines success not as assimilation but as authenticity, continuity, and pride. It is through this lens that their educational journeys must be understood, not as linear paths of upward mobility, but as complex negotiations of identity, belonging, and self-worth. This process of maintaining class identity in elite spaces reflects broader sociological insights into how individuals actively construct and preserve their sense of self in response to institutional expectations (Friedman et al, 2021; Skeggs, 1997; Reay, 2017).

In contrast, Joanna, a third-year student, offers a more linear interpretation of class mobility:

> I think anyone who would see me outside of my training, sees me as working class because of my home location, small house, due to family finances, etc, but with regards to what I think my class is, my trajectory would put me as middle class.

Joanna's narrative reflects a more individualised understanding of class, where mobility is measured by educational and professional advancement. However, this perspective can overlook the emotional and cultural dissonance that often accompanies such transitions. While she identifies with a middle-class future, her material circumstances and social background continue to shape how others perceive her, and how she perceives herself.

These narratives collectively challenge simplistic notions of class as a fixed or easily measurable category. Instead, they reveal class as a dynamic and relational identity, shaped by context, comparison, and emotional experience. The university, particularly within competitive and elite programmes like medicine, becomes a site of class revelation. In this space, students begin to understand the structural inequalities that have shaped their educational journeys.

This process is not merely cognitive but deeply affective (Skeggs, 2012). Students often describe feelings of inadequacy and shame as they confront the unspoken norms of

academic life. Yet, these moments of discomfort also open space for critical reflection and solidarity. They mark the beginning of a more politicised understanding of class, not just as a background characteristic, but as a lived and contested identity.

In sum, the university experience acts as a mirror, reflecting to working-class students the realities of social stratification that were previously obscured. This reflection can be painful, but it also opens space for critical awareness, resistance, and the reassertion of working-class identity on their terms.

The participant narratives provide an examination of how working-class medical students develop class consciousness through their experiences within elite university environments. The narratives of Louise, Joe, Zena, Chantal, Ted, and Joanna reveal that class identity is not fixed or immediately visible, it emerges through contrast, emotional labour, and the confrontation with dominant institutional norms. For many, university represents the first time they recognise their working-class background as a source of difference, shaped by unequal access to resources, cultural familiarity, and institutional expectations (Reay, 2017; Friedman and Laurison.

These moments of recognition prompt students to critically reflect on their social positioning. They begin to understand that their educational journeys are not solely defined by personal effort but are shaped by broader structural inequalities that privilege middle-class norms. Through this awareness, students move toward a more reflexive understanding of class, developing the capacity to navigate institutional spaces while maintaining pride in their origins (Reay, 2015).

Drawing on Yosso's (2005) framework of community cultural wealth, this chapter highlights the valuable forms of capital that working-class students bring to higher education, resilience, familial support, and cultural knowledge. These assets challenge deficit-based narratives and affirm the legitimacy of working-class identity within academic and professional contexts.

The findings also underscore the limitations of widening participation policies that prioritise access without addressing the deeper cultural exclusions that persist. Zena's narrative illustrates that inclusion without transformation can lead to heightened visibility and a sense of cultural dissonance, rather than genuine belonging.

Ultimately, the development of class consciousness among working-class medical students is a complex and relational process. It involves negotiating identity, resisting assimilation, and asserting value in spaces that often fail to recognise it. The university becomes a site of revelation, where the hidden benefits of privilege are exposed, and students begin to reassert their identities on their own terms, using their own capital (Yosso, 2005), not that of the dominant class.

Working-Class Resistance and Pride

The successful transition through medical education for working-class students is not merely an academic pursuit; it is a deeply embodied negotiation of identity, belonging, and legitimacy. As students enter elite university spaces, they are often confronted with the realisation that their cultural and social capital diverges significantly from the dominant norms. This moment of recognition, as Louise (Year 3) articulates, is both disorienting and illuminating:

> I didn’t know I was disadvantaged until I got to university. I just thought everyone had to work hard to get into med school, and they do, but some harder than others.

Louise’s reflection echoes Reay’s (2017) assertion that class is often rendered invisible until one enters a space where middle-class norms dominate. The university becomes a site of class revelation, where the ideology of meritocracy is exposed as partial and exclusionary. As Friedman and Laurison (2020) argue in The Class Ceiling, access alone does not dismantle inequality; rather, it often reconfigures it through subtle mechanisms of symbolic violence (Bourdieu, 1990). These mechanisms include the unspoken rules of behaviour, language, and self-presentation that privilege those already fluent in middle-class cultural codes (Bathmaker et al, 2018; Ball et al, 2002).

At the outset of their decision to apply to medicine, most of these students were not driven by a desire to transcend or disown their class background. Rather, they were motivated by a search for security, stability, and a meaningful contribution. For many, medicine represented a career that offered both personal fulfilment and a way to ‘pay back’ the sacrifices their families had made. None of the participants in this study aspired to become ‘better than’ their background. Instead, they simply wanted to become doctors and worked hard against systems of exclusion to reach that goal. This motivation challenges dominant narratives of social mobility that cast success as escape or transformation. As Byrom (2009) and Reay et al. (2009) argue, working-class students often reject the idea that upward mobility requires cultural assimilation. For these students, success is not about joining a tribe to become like everyone else; it is about leading themselves with pride towards a secure future in a meaningful role. This is a form of authentic mobility, a movement that retains a connection to origin rather than severing it (Ingram, 2009; Paulson, 2018).

Rather than assimilating into dominant norms, many students in this study actively resist them. This resistance is not always overt; it is often expressed through the preservation of working-class values, speech, and relational practices. Chantal (Year 2) offers a powerful example:

> Whilst my education and career choice may be seen as 'middle-class', my experiences of attending university as a first-generation, scholarship student and my social interactions are wholly working-class. I also don't see my career as my defining character trait, so all of my interactions and experiences outside my training remain firmly 'working-class‘.

Chantal’s narrative illustrates what Yosso (2005) terms resistant capital, the knowledge and skills fostered through oppositional behaviour that challenges inequality. Her refusal to let her professional identity overwrite her class identity is a form of cultural defiance, a way of asserting that success does not require erasure. This aligns with Skeggs’ (1997) concept of respectability, where working-class individuals assert moral worth through hard work, loyalty, and authenticity, often in contrast to the performative professionalism expected in elite institutions.

This redefinition of success is central to the lived experiences of many participants. Rather than viewing success as upward mobility or assimilation, students like Ted (Year 2) and Louise frame it as survival with integrity. Their stories align with Skeggs’ (2011) notion of value practices, where working-class individuals assert moral and emotional worth in ways that resist commodification and institutional judgment. These practices are not simply

reactive but are rooted in a deep sense of identity and community, often shaped by intergenerational experiences of marginalisation (Lawler and Byrne, 2005; Ingram, 2009).

> I faced many challenges growing up working-class, around relative poverty. This made me very resilient, deeply independent and very driven to pursue a more financially stable life for myself (Louise, Year 3)

Here, resilience is not framed as a neoliberal virtue but as a survival strategy born from structural adversity. It reflects what Reay (2015) calls psychosocial resistance, a refusal to internalise the shame often attached to working-class identities in elite spaces. This emotional labour, often unrecognised by institutions, is central to the working-class student experience (Loveday, 2015; Rickett and Morris, 2020). It is also a form of what Hochschild (2003) describes as emotional management, where students must regulate their feelings to maintain composure and credibility in unfamiliar and often exclusionary environments.

Moreover, these narratives challenge the dominant metrics of success in higher education. As Bathmaker et al. (2018) argue, the degree alone does not guarantee social mobility; rather, the ability to navigate, and sometimes subvert, institutional cultures define meaningful success for many working-class students. This is particularly salient in medicine, where professional identity is tightly regulated and class-coded (Brosnan and Turner, 2009; Balmer et al, 2017). The hidden curriculum of medical education, its implicit values, norms, and expectations, often reinforces middle-class dispositions and marginalises those who do not conform (Hafferty, 1988; Michalec, 2011).

In this context, success is reimagined not as conformity but as authenticity, the ability to remain rooted in one's values while navigating elite spaces. It is a form of cultural endurance, a quiet but powerful resistance to the erasure of working-class identity. As such, these students are not only surviving but reshaping what it means to belong and to succeed in higher education. Their presence and persistence challenge the myth of a classless meritocracy and demand a broader, more inclusive understanding of what success looks like in the academy and beyond.

'We All Work Hard': Pride, Respectability, and the Emotional Labour of Class

This chapter explores the lived experiences of working-class medical students as they navigate the complex terrain of higher education and professional identity formation. It focuses on the emotional, cultural, and symbolic labour involved in transitioning into elite academic and clinical environments, while maintaining ties to home, community, and class identity. Drawing on qualitative data from student narratives, the chapter interrogates how classed experiences shape belonging, aspiration, and resilience within the context of widening participation in UK medical education.

The chapter begins by critically examining the illusion of a 'classless' university environment, highlighting how neoliberal discourses of meritocracy obscure the structural inequalities embedded in higher education. It then introduces key theoretical frameworks, particularly Bourdieu's concepts of habitus, capital, and symbolic violence, alongside Skeggs' and Reay's work on respectability and emotional labour to analyse how working-class students negotiate identity and legitimacy in unfamiliar institutional spaces.

Subsequent sections explore themes of pride, loyalty, and the burden of representation, illustrating how students draw on familial and moral capital to assert their value in systems that often misrecognise or marginalise their contributions. The chapter also considers the psychosocial costs of upward mobility, including the tensions between authenticity and assimilation, and the emotional toll of navigating exclusionary norms.

By foregrounding the voices of working-class students, this chapter challenges deficit-based narratives and calls for a more nuanced understanding of inclusion, one that recognises the affective and cultural dimensions of class, and the need for institutions to value diverse forms of capital. In doing so, it contributes to broader debates about equity, belonging, and transformation in the field of medical education.

The expansion of widening participation (WP) in UK universities has been widely promoted as a mechanism for increasing equity in higher education. However, this expansion often creates what Hanley (2017:12) describes as the illusion of a ‘classless environment’. This illusion is rooted in the belief that simply granting access to elite institutions is sufficient to dismantle the deeply embedded structural inequalities within the English education system. Yet, as Reay (2017) and Bathmaker et al. (2018) argue, access alone does not equate to inclusion. The university remains a space where middle-class norms dominate, and where working-class students must navigate unfamiliar cultural codes and expectations.

This illusion is further reinforced by neoliberal discourses that frame education as a meritocratic ladder, where success is attributed to individual effort rather than structural advantage (Livesey, 2019, Reay, 2017). Such narratives obscure the cultural and emotional labour required of working-class students to succeed in environments that were not designed with them in mind. As Bourdieu (1990) suggests, those whose habitus aligns with institutional norms move through these systems with ease, like ‘a fish in water’. For others, particularly those from working-class backgrounds, the experience is more turbulent, marked by a sense of dislocation and symbolic violence (Bourdieu, 1991, Skeggs and Loveday, 2012).

The university experience often becomes the site where working-class students first become acutely aware of their social positioning. Prior to entering higher education, class may not have been a prominent part of their identity, particularly in communities where shared economic hardship is normalised. As participants in this study reveal, class consciousness frequently emerges in contrast to the dominant culture of the university, which can feel alien and exclusionary. This awakening is compounded by the dissonance between lived realities and media portrayals of the working class as feckless, lazy, or undeserving, a narrative that many students find both inaccurate and damaging (Tyler, 2015, Shildrick, 2018).

Despite the erosion of traditional working-class communities, once centred around industries like mining or manufacturing, a strong sense of pride in working-class identity persists. The participants in this study consistently evidenced this pride, often framing their backgrounds as a source of strength and resilience. Their narratives were rich in references to the value of hard work, the sacrifices made by their families, and the moral worth of perseverance. These values, embedded in the working-class habitus, are not only cultural but also moral, serving as a counter-narrative to dominant stereotypes and as a source of strength in navigating elite spaces (Reay, 2015; Yosso, 2005).

A recurring theme across participant narratives was the expression of pride in working-class identity, an identity grounded not in deficit, but in dignity, resilience, and moral value. This pride was frequently articulated through references to family labour and sacrifice, positioning hard work as both a personal ethic and a collective legacy. However, beneath these affirmations lies a complex layer of emotional labour: the ongoing effort to maintain self-worth, perform legitimacy, and navigate academic environments that often fail to recognise or value these forms of capital.

Natasha (Year 3) provides a good example of pride and moral values,

> I consider myself working-class, I work really hard. I am the first person in my family to attend university. My dad drives a bus… We all work hard.

Natasha's account is more than a declaration of identity; it reflects the emotional and symbolic labour embedded in the experience of being a first-generation university student. Her success is not framed as an individual triumph but as a collective achievement rooted in a shared family ethic. This resonates with Skeggs' (2004, 2012) concept of the moral economy of working-class respectability, in which value derives not from economic capital but from responsibility, endurance, and care. Similarly, Lawler (2005) argues that working-class subjectivities are often shaped by affective ties to family and community rather than by institutional validation. Natasha's narrative exemplifies this, positioning familial solidarity as a source of strength and legitimacy.

Yet, this pride is accompanied by pressure. Being 'the first' carries an implicit emotional obligation to succeed not only for oneself, but also on behalf of one's family. This burden of representation, as Reay (2005) describes, imposes a high psychic cost. Students like Natasha must constantly perform competence, gratitude, and resilience, even in the face of institutional alienation or class-based microaggressions (Reay et al, 2009). Her assertion that 'we all work hard' functions as both affirmation and defence: it affirms her family's moral legitimacy in a system that often marginalises working-class experiences, while also reflecting an internalisation of meritocratic ideals. As Hanley (2019) notes, working-class pride can serve as a form of resistance to the shame historically associated with poverty and manual labour, but it can also obscure the structural inequalities that shape educational trajectories.

This aligns with the motivations identified by Lempp, who highlights the 'strong motivation to become a doctor, support from family members, and the high social status of medicine combined with an expected ethos of hard work' (Lempp in Brosnan and Turner, 2009:76). This emotional labour is not unique to Natasha. It reverberates across the accounts of other participants, such as Meg and Jake, who similarly navigate the tension between pride in their origins and the institutional pressures that often render those origins invisible or misunderstood.

Meg (Year 4) articulates this tension with clarity and conviction:

> I am working-class from a council estate, my parents didn't go to uni, but they work hard.

Meg's narrative resists the deficit framing often imposed on working-class students. Rather than distancing herself from her background, she embraces it as a source of strength and legitimacy. Her pride is not only personal, but political; it challenges the assumption that

success requires disavowing one's origins. This aligns with Skeggs' (1997) analysis of how working-class women construct value through moral discourses of hard work and care, asserting their worth in spaces that often devalue their cultural capital (Bourdieu, 1986).

Jake (Year 4) adds another dimension, highlighting the emotional and material consequences of institutional misrecognition:

> I grew up with just my and my mum. My mum is a receptionist for a doctor. I owe everything to how hard she has worked to support me.

Jake's narrative shows gratitude, but also the emotional labour of representation. His pride in his mother's work is evident. Nevertheless, it also signals the weight of obligation to succeed, to justify her sacrifices, and to navigate a system that often fails to understand the realities of working-class life. His story, like Natasha's and Meg's, illustrates that working-class pride is not simply a personal sentiment, but a strategic and affective response to environments that frequently fail to recognise the full humanity of students from non-traditional backgrounds.

A recurring theme across these accounts is loyalty, a deeply held value among working-class participants. This loyalty is not only directed toward family, but also toward community and cultural identity. Notions of 'escaping' one's past to 'become' middle-class were notably absent. While participants expressed a desire for security and reduced precarity, they did not frame this as a rejection of their origins. Instead, they articulated a strong sense of pride and responsibility toward their families and communities. As Reay (2017) and Hanley (2016) argue, the educational trajectory often entails a painful negotiation between aspiration and a sense of belonging. The idea that success requires sacrificing a part of oneself, friendships, familiarity, and cultural identity is a recurring tension in the narratives of socially mobile students.

In sum, the accounts of Natasha, Meg, and Jake reveal the complex interplay between pride, pressure, and loyalty in the lives of working-class students. Their stories challenge simplistic narratives of social mobility and highlight the emotional labour required not only to succeed academically but to remain visible, valued, and authentic within institutions that often reward assimilation over authenticity.

The concept of hard work is often central to the identity and values of working-class people. This emphasis on hard work serves multiple functions, from asserting moral worth to resisting stigma and navigating structural inequalities. Hard work is deeply embedded in working-class communities' cultural and moral identity. As Skeggs (1997) and Hanley (2019) argue, working-class individuals often construct their identities around being responsible, self-reliant, and industrious. This moral identity is not just about economic survival but also about asserting dignity and respectability in a society that frequently devalues their contributions. The narratives of hard work serve as a counter-narrative to the dominant stereotypes that frame working-class people as lazy or lacking ambition (Tyler, 2015; Shildrick, 2018).

In a society that often stigmatises poverty and working-class life because of laziness or poor choices, asserting a strong work ethic becomes a form of resistance. It challenges dominant narratives that blame individuals for structural inequalities. As Shildrick (2018) and Tyler (2015) highlight, media representations often reinforce negative stereotypes of the working

class. By emphasising hard work, working-class individuals resist these stigmatising narratives and assert their moral worth. Hard work is also a way to honour the sacrifices of previous generations. Many working-class students speak with pride about their parents' or grandparents' labour, whether in care work, bus driving, or cleaning. This pride is not just about economic survival but about moral continuity and family legacy. As Reay (2019) notes, the values of hard work and resilience are passed down through generations, reinforcing a sense of identity and community.

In a meritocratic society, where success is based on effort and ability, working-class individuals often internalise the idea that hard work is the key to upward mobility. Even when they recognise the system is unequal, they may still cling to hard work as a strategy for survival and self-worth. However, as Friedman and Laurison (2020) argue, the myth of meritocracy often obscures the structural barriers that working-class individuals face, making their hard work even more significant as a form of resistance and self-assertion.
The emotional and psychological dimensions of hard work are also significant. As Loveday (2015) and Reay (2017) explore, working-class individuals often experience shame, alienation, and a sense of not belonging within elite academic environments. Emphasising hard work becomes a way to cope with these feelings and to assert a positive identity in the face of exclusion and misrecognition.

Her pride in labour reflects what Skeggs (1997) terms 'moral capital', a way of asserting value in a society that often devalues working-class contributions. Nevertheless, within the university, this moral capital is rarely recognised. Instead, students must perform a form of cultural translation, learning to navigate spaces where their ways of speaking, dressing, and relating are subtly marked as 'other' (Bourdieu, 1991; Reay, 2015). This duality reflects what Bourdieu (1990) describes as 'cleft habitus', a psychosocial conflict between the social world one comes from and the one they now inhabit. For working-class students, this dissonance is lived daily in conversations, social comparisons, and institutional expectations.

Despite these challenges, many students resist complete assimilation. They draw strength from their backgrounds and use their experiences to inform their practice. Alex, a fourth-year student, reflected,

> Sometimes I worry that as I get more experience, I will become like my peers. Will I one day be someone who asks a trainee who cannot afford their tea, where they will ski this year?

This fear of losing authenticity is not just personal; it is political. It reflects a desire to remain connected to the values of care, humility, and community that define working-class life (Skeggs and Loveday, 2012). These values are not merely sentimental; they are epistemological. As Yosso (2005) argues, working-class students possess forms of community cultural wealth, navigational, resistant, and familial capital that are often overlooked in institutional settings. Their ability to navigate unfamiliar environments, persist in the face of exclusion, and remain grounded in their communities is not a deficit, but a strength. However, as Reay (2015) notes, the emotional cost of this navigation is high. Students must constantly manage the tension between maintaining a sense of self and succeeding in an alien environment.

The narratives of these students challenge dominant discourses of meritocracy and inclusion. They reveal that access alone does not equate to belonging, and that true equity requires recognition of the emotional and cultural labour involved in navigating elite spaces. As Friedman and Laurison (2020) argue, the ‘class ceiling’ is not only about who gets in, but about who feels they belong once they are there. For working-class medical students, the journey is not just about becoming a doctor; it is about becoming someone who can survive, and perhaps even thrive, in a system that was not built with them in mind.

By foregrounding their lived experiences, working-class medical students not only assert their place within the profession but also expand its moral and cultural boundaries. Their presence is not a token of diversity but a challenge to the very norms that have historically excluded them. In doing so, they offer a vision of medicine that is not only more inclusive but more human.

For many working-class students, finding solace among people from similar backgrounds can be key to maintaining authenticity (Reay, 2005). However, on elite programmes such as medicine, working-class students may be in short supply. These social connections must be found elsewhere. In Josh’s case (year 2), this is in his student accommodation.

‘I was lucky that in year one I made friends with some students in my halls. They are not medical students, but we get along. Our term dates are slightly different, and because I am constantly revising, it can be challenging. But at least I feel included at home’. Similarly, Tiffany (year 5), has struggled throughout her studies to find a connection, although unlike Josh, Tiffany does not feel lucky as she discusses;

> I have faced a lot of classism here; some comments from other students have been really hurtful. What is worse is that many don’t even see it as a problem. They make fun of accents or where people are from, like working-class backgrounds don’t belong here. It’s clear they don’t realise, or care, that some of us are from those backgrounds.

Tiffany’s experience highlights how classism is often embedded in everyday interactions that become normalised within elite educational contexts. As Reay (2005) observes, accent, background, and place serve as markers for policing belonging, and Tiffany’s story shows how casual remarks can reinforce dominant assumptions about who qualifies as a legitimate medical student. The ease with which these comments are made, and the failure to recognise their harm, reflect a broader culture of misrecognition, subtly positioning working-class identities as inferior or out of place (Reay, 2017; Skeggs, 1997).

This sense of exclusion is further heightened by material insecurity. Recent findings from the Sutton Trust (2023) reveal that nearly 25% of university students skip meals to cover basic living costs, and almost 50% rely on family financial support. However, many working-class students have limited or no access to these safety nets, leaving them more vulnerable to rising expenses. This disparity underscores ongoing structural inequalities that influence participation in higher education, especially in resource-intensive and time-demanding programmes such as medicine, where emotional and financial pressures combine and amplify feelings of marginalisation. This additional pressure was evident in many of the participants' narratives.

Jake, a fourth-year medical student, recounted a disheartening experience when seeking support from his academic tutor:

> When I told my academic tutor that I was struggling with money, she asked if I had a rich uncle who could help. I explained that I do not have anyone who can help me financially. After the meeting, she sent me some links to information on how to manage money well. I cannot manage what I haven't got.

Jake's experience exemplifies the institutional misrecognition of class-based hardship. His tutor's response, framed through a lens of assumed privilege—reflects what Bourdieu (1990) terms symbolic violence: the imposition of dominant cultural norms that render working-class realities invisible or illegitimate. The suggestion that financial hardship can be resolved through budgeting advice ignores the structural nature of poverty and reinforces the idea that financial struggle is a personal failing rather than a systemic issue.

Josie, a second-year student, echoed this frustration:

> We are often told that medicine is a full-time course, and that paid work should either not happen or be minimal. I do understand, but I have no choice, I do not have enough money!

Her statement highlights the contradiction between institutional expectations and lived realities. While medical schools often discourage part-time work to protect academic performance, they fail to provide adequate financial support for students who cannot rely on family wealth. This creates a double bind: students are expected to perform as if they are financially secure, while simultaneously being denied the means to achieve that stability.

These narratives reveal a broader institutional failure to recognise the diversity of student experience. As Riddell (2003:185) argues, neoliberal universities often 'ignore issues of identity, assuming that individuals experience particular social policy regimes in very similar ways'. This assumption of homogeneity is particularly damaging in medicine, where the student body remains disproportionately drawn from privileged backgrounds (Friedman and Laurison, 2020). For many staff, the normalisation of financial ease among students is not malicious but experiential, rooted in repeated encounters with students who do not need to worry about money. However, this normalisation marginalises those who do.

Alex, a fourth-year student, captured this dissonance:

> It is so strange being surrounded by people who have zero money worries. They cannot grasp studying without concern; for many working-class people, life is about getting by. University is often the first time where people who do not need to worry about making ends meet become part of our network.

Alex's reflection illustrates the emotional and social alienation that arises when working-class students are immersed in environments where financial security is assumed. His use of the term 'network' is particularly telling; it suggests that the university is not just a site of learning, but a social field where classed identities are constantly negotiated. The presence of peers who have never experienced financial precarity can intensify feelings of difference and exclusion, reinforcing the sense of being an outsider.

Moreover, the lack of financial resources creates what Reay (2015) describes as a 'poverty of opportunity'. Students who must work to survive often miss out on unpaid placements,

extracurricular activities, and networking events that enhance employability. This compounds inequality, as those with the least support are also those most likely to be excluded from the informal opportunities that shape professional success.

Ultimately, these accounts reveal that widening participation must go beyond access. Without structural changes to how financial need is understood and supported, inclusion remains superficial. Institutions must move from a model of assumed sameness to one of responsive difference—recognising that equity requires more than equal treatment; it demands an understanding of unequal starting points and the provision of meaningful, tailored support.

Working-class medical students must quickly assimilate into the alien environment of the university, its unspoken rules, and its unfamiliar language. As Reay (2015) suggests, the attempt to transform the self to fit can harm individual identity, not only by unlearning what has been learned over a lifetime but also by resetting one's biography. Self-reflection and a new understanding that working-class norms and practices are ‘not good enough’ are required, and, for many, this creates a recognition that people like them and their community are judged as less (Reay, 2006; 2015).

In summary, while widening participation initiatives aim to create a more inclusive university environment, a misunderstanding of the working-class student, their challenges, as well as their positive attributes, can create exclusion. Arguably, more work is needed to understand the deeper structural and psychosocial barriers that working-class students face. Recognising and supporting the unique challenges and strengths of these students is crucial for fostering true inclusivity and equity in higher education.

This chapter has explored the experiences of working-class medical students, highlighting their motivations, challenges, and the impact of their class identity on their educational journey. Utilising Bourdieu's (1977) concept of habitus, this chapter has examined how deeply ingrained habits, skills, and dispositions shape these students' perceptions and actions within the medical school environment.

The narratives of students like Josh, Zena, Leon, and others illustrate the profound influence of working-class habitus on their pursuit of a medical career. Their stories reveal a collective mindset of resourcefulness, responsibility, and a strong sense of duty towards others. While invaluable in the medical profession, these traits often come at a personal cost, particularly in educational outcomes.

Despite the progress made through initiatives to improve access to medicine, working-class students remain underrepresented in the medical field. The persistence of structural barriers and the normalisation of privileged backgrounds within elite professions highlight the need for more comprehensive and inclusive policies. These policies must address not only economic obstacles but also the broader social inequalities and psychosocial challenges that working-class students face when considering medicine as a career and when entering university life early.

The concept of working-class habitus underscores the importance of recognising and valuing the unique strengths and contributions of these students. Their ingrained values of community, resourcefulness, and a committed work ethic can significantly enhance patient care and foster a more inclusive and empathetic medical profession. We can move towards

a more equitable and representative healthcare system by acknowledging and supporting the working-class habitus.

However, these barriers persist within universities, and inclusion initiatives for working-class students often focus solely on economic obstacles. While these interventions are beneficial, they tend to overlook the broader impact of social inequalities, habitus, and psychosocial challenges. Additionally, they fail to recognise the extra emotional labour required for these students to meet the entry requirements for programs such as Medicine (Reay, 2004; Reay, 2015; Friedman and Laurison, 2020).

Friedman and Laurison's (2020) research found that fewer than 5% of doctors came from working-class backgrounds. This figure represents an improvement on the Social Mobility Commission's 2016 report, which found that just 4% of doctors were from working-class backgrounds (Social Mobility Commission, 2016). The medical students in this research were aware of their minoritised position. As Louise, a year 3 student, discusses,

> It is so difficult not to compare lives when I know I am in the minority. However, despite the now-obvious disadvantage, I didn't realise I was at a disadvantage until I got to university. I just thought everyone had to work hard to get into med school, and they do, but some harder than others. I achieved the best possible A levels. I faced many challenges growing up working-class, around relative poverty. This made me resilient, deeply independent, and driven to pursue a more financially stable life for myself.

Louise's determination and capacity for self-reflection are admirable, and they underscore an important truth: students do not leave their personal histories at the university gates. For many working-class students, the ideal of meritocracy fuels their ambition, but the reality of university life can be jarring. The transition often exposes stark differences in background, opportunity, and experience between themselves and their more privileged peers. This awareness can be both empowering and disorienting, highlighting the resilience and adaptability required to thrive in such unfamiliar environments (Reay, 2005).

Consequently, working-class medical students must quickly assimilate into the university's alien environment, including its unspoken rules and unfamiliar language. As Reay (2015) suggests, the attempt to transform the self to fit can harm individual identity, not only by unlearning what has been learned over a lifetime but also by resetting one's biography. Self-reflection and a new understanding that working-class norms and practices are 'not good enough' are required, and for many, this leads to the recognition that people like them and their community are judged as less (Reay, 2006; 2015).

Josie (year 2 student), outlines this well,

> I am proud of my achievements. I am proud of my family and their achievements, and I like to tell people about my family. They have not been to uni, but they have done remarkable things.

In summary, while widening participation initiatives aim to create a more inclusive university environment, a misunderstanding of the working-class student, their challenges, as well as their positive attributes, can create exclusion. Arguably, more work is needed to understand the deeper structural and psychosocial barriers that working-class students face. Recognising and supporting the unique challenges and strengths of these students is crucial for fostering true inclusivity and equity in higher education.

This chapter has explored the experiences of working-class medical students, highlighting their motivations, challenges, and the impact of their class identity on their educational journey. Utilising Bourdieu's (1977) concept of habitus, this chapter has examined how deeply ingrained habits, skills, and dispositions shape these students' perceptions and actions within the medical school environment.

The narratives of students like Josh, Zena, Leon, and others illustrate the profound influence of working-class habitus on their pursuit of a medical career. Their stories reveal a collective mindset of resourcefulness, responsibility, and a strong sense of duty towards others. While invaluable in the medical profession, these traits often come at a personal cost, particularly in educational outcomes.

Despite the progress made through initiatives to improve access to medicine, working-class students remain underrepresented in the medical field. The persistence of structural barriers and the normalisation of privileged backgrounds within elite professions highlight the need for more comprehensive and inclusive policies. These policies must address not only economic obstacles but also the broader social inequalities and psychosocial challenges that working-class students face when considering medicine as a career and when entering university life early.

The concept of working-class habitus underscores the importance of recognising and valuing the unique strengths and contributions of these students. Their ingrained values of community, resourcefulness, and a committed work ethic can significantly enhance patient care and foster a more inclusive and empathetic medical profession. We can move towards a more equitable and representative healthcare system by acknowledging and supporting the working-class habitus.

This chapter demonstrates that working-class students are aware of the complex interplay between their working-class habitus and the social interactions they encounter when entering elite training programs, such as medicine. However, their motivations and understanding of the importance of care have the potential to create both more equitable training programmes and better patient care. Fostering true inclusivity and equity in higher education and the medical profession requires a deeper understanding of the structural and psychosocial barriers faced by working-class students. Recognising their unique challenges and strengths is crucial for creating an environment where all students can thrive and make meaningful contributions to the medical field. The students are already aware that the policymakers and providers of training and healthcare systems would benefit from listening.

Pride does not pay the bills

The emotional toll of financial precarity on working-class medical students is both profound and multifaceted. Beyond the immediate stress of managing basic living costs, students often experience anxiety, shame, and a diminished sense of self-worth, particularly when their struggles are misunderstood or dismissed by institutional actors. Reay (2019) argues that working-class students in elite educational spaces frequently endure a ‘psychic cost,’ a form of emotional strain that arises from navigating environments where their identities and experiences are not fully recognised or valued.

This emotional burden is compounded by the UK’s ongoing cost-of-living crisis, which has intensified the financial pressures already faced by students in higher education. For those enrolled in demanding, inflexible programmes such as medicine, the impact is particularly

acute. The crisis is not merely a temporary economic downturn but a structural issue marked by sustained inflation, stagnant student support, and escalating costs for essentials such as rent, energy, transport, and food. These rising expenses have outpaced the value of maintenance loans and bursaries, leaving many students unable to meet their basic needs without taking on additional paid work (Connor, 2024; BMA, 2025; Latham, 2025).

As Reay (2018) and Jones (2016) note, working-class students often enter higher education with fewer financial resources and limited family safety nets, leaving them particularly vulnerable to economic shocks. Unlike their more privileged peers, they cannot rely on parental subsidies or savings to absorb the impact of rising costs. This disparity is not only economic but also symbolic, reinforcing a sense of exclusion and misrecognition within the university environment (Reay et al., 2001; Skeggs and Loveday, 2012).

The lived experiences of students like Louise, a Year 3 medical student, bring these structural issues into reality:

> The increasing cost of living is making me stressed and anxious, as I have had to give up study time to work and support myself financially. Juggling full-day university clinical placements with a job is impacting my academic performance. Sometimes it is too much.

Louise's account illustrates what Bhatti (2009) describes as the 'emotional labour' of navigating higher education without adequate support. The expectation that students should manage their finances while maintaining academic excellence overlooks the structural inequalities that shape their experiences. As Riddell (2003:185) observes, neoliberal institutions often assume a homogenous student body, failing to account for the differentiated impact of policy and economic conditions on students from diverse backgrounds.

As Harvey (Year 2) discusses,

> The first two years were hard to fit with a paid job; this year is so difficult. I need my job to survive. I wish I had stayed at home to study.

The inadequacies of the current student finance model exacerbate this disconnect. Maintenance loans, which are means-tested and capped, frequently fall short of covering actual living expenses. Increasingly, most students are concerned about the cost of studying. However, only those from disadvantaged backgrounds understand these costs as restrictive (Greenhalgh, 2015). As a result, students are often compelled to seek paid employment, despite the incompatibility of work with the demands of medical training (Sutton Trust, 2025). Boursicot and Roberts (2009) highlight that the structure of medical education, with its long hours, clinical placements, and high academic standards, leaves little room for part-time jobs, placing students like Louise in an untenable position.

Moreover, the financial burden extends beyond tuition and rent. Hidden costs, such as travel to placements, professional attire, digital access, and essential equipment, are rarely included in financial aid packages. These additional expenses disproportionately affect students without external support (Reay, 2017; Greenhalgh et al., 2015), limiting their ability to fully engage with the curriculum, participate in enrichment activities, or maintain their wellbeing.

The psychological consequences of this financial strain are well documented. Gilbert (2018) and Reay (2019) both highlight how financial stress contributes to anxiety, depression, and a sense of alienation, particularly when students feel unsupported or misunderstood by staff. These emotional burdens are compounded by what Bourdieu (1990) and Skeggs and Loveday (2012) describe as symbolic violence, subtle institutional practices that devalue the lived experiences of working-class students.

This normalisation of privilege within medical education further entrenches inequality. As Friedman and Laurison (2019) demonstrate, elite professions like medicine are predominantly populated by individuals from professional and managerial backgrounds. Their experiences shape institutional assumptions, often leading staff to presume that all students have access to financial support unconsciously. This reinforces a culture of silence around class-based disadvantage and results in what Reay (2015) terms ‘misrecognition’, a failure to acknowledge and value the realities of working-class students, which in turn undermines their sense of belonging and academic confidence.

The necessity to earn money has far-reaching consequences for students’ ability to balance academic and financial responsibilities. Amina, a Year 2 student, shared:

> I work night shifts at a care home on weekends. I’m exhausted by Monday morning, but I can’t afford not to work. I’ve fallen asleep in lectures more than once. It’s embarrassing, but I don’t have a choice.

Amina’s experience is not unique. Moir et al. (2018) and Hayat et al. (2020) found that financial stress among medical students is strongly correlated with symptoms of anxiety, depression, and burnout. These findings underscore the need for institutions to move beyond surface-level support and address the structural conditions that produce emotional distress.

Medical students face unique challenges in securing paid work due to the intensive and inflexible nature of their training. Unlike students in other disciplines, they are required to attend full-day clinical placements, often with long commutes and emotionally demanding schedules. These placements, combined with frequent assessments and high expectations for professionalism, leave little capacity for additional employment (Greenhalgh et al, 2004; Boursicot and Roberts, 2009). As a result, students who must work to survive are placed at a significant disadvantage.

Institutional inflexibility further compounds this issue. Universities often discourage paid employment among medical students, citing concerns about academic performance and patient safety. However, this stance fails to account for the realities faced by students who have no alternative means of financial support. As Bhatti (2009) and hooks (2014) argue, institutions must recognise difference without pathologising it, acknowledging that some students face greater barriers and require more nuanced support.

Jake’s experience exemplifies what Bourdieu (1997) terms symbolic violence—the subtle, often unintentional imposition of dominant cultural norms that delegitimise the lived realities of marginalised students. His tutor’s response reflects what Shildrick (2018) critiques as the individualisation of poverty, where structural hardship is reframed as a matter of personal responsibility. Jake’s refusal to accept this logic is itself a form of resistance. His narrative challenges the assumption that working-class students need to ‘manage better’ and instead asserts that, without adequate resources, financial management is impossible.

The experiences shared by students like Louise, Amina, and Jake show that while theories can help us understand inequality, they do not always capture the whole picture. Bourdieu's (1996) framework of field, habitus, and social, cultural and economic capital helps explain how universities often favour middle-class ways of thinking and behaving, making working-class students feel out of place. However, his work can sometimes make it seem as though these students are stuck in their situation, with little room to push back or succeed on their terms. Alternatively, Yosso's (2005) work reminds us that working-class students bring valuable strengths, such as determination, strong family ties, and the ability to navigate complex systems.

Focusing solely on the personal strengths of working-class students—such as determination or adaptability—can obscure the structural inequalities they face. No matter how committed or capable a student may be, systemic barriers like economic hardship, cultural exclusion, and institutional bias can severely limit their ability to succeed. As Jerjes and Majeed (2025) note, 'the economic stress of medical training exacts a real cost on trainee wellbeing,' underscoring that individual effort cannot compensate for structural disadvantage.

When students are forced to skip meals or miss lectures to work night shifts, it is not a matter of lacking resilience—it is a failure of the system to provide equitable support. Universities must move beyond symbolic recognition of struggle and instead reconfigure their understanding of success. This means acknowledging students' unequal starting points and implementing meaningful, structural interventions to address those disparities.

Without such changes, widening participation risks becoming a hollow promise—offering access without inclusion, and opportunity without fairness. As Reay (2017), Bathmaker et al. (2018), and Byrom (2009) argue, true equity in higher education requires more than opening the door; it demands transforming the conditions within.

Hidden Costs, Familial Disadvantage, and the Cost-of-Living Crisis

In addition to the widely felt cost-of-living crisis across the UK, medical courses often incur additional costs that are not equally distributed across degree programmes. While tuition fees and accommodation costs are widely acknowledged, the hidden costs of studying medicine, such as travel to placements, professional attire, textbooks, equipment, and digital access, are often overlooked. These costs disproportionately affect working-class students, who are less likely to have access to financial support from family and more likely to experience financial hardship throughout their studies (Reay, 2017; Sutton Trust, 2023).

Callum, a Year 5 student, shared:

> I've had to turn down a hospital placement I wanted because I couldn't afford the travel and accommodation. It's gutting. These opportunities are meant to help us develop our areas of interest as part of our training, but they are not accessible to everyone. Some of us are limited to staying close to the accommodation we have already paid for.

Callum's experience exemplifies a broader pattern of exclusion. As Greenhalgh et al. (2004) and Boursicot and Roberts (2009) point out, medical education is built on assumptions of financial flexibility, expecting students to travel long distances for placements, buy specialised equipment, and attend unpaid clinical experiences without institutional

compensation. These expectations are embedded in what Reay et al. (2001) describe as the institutional habitus, a set of unspoken norms that reflect and perpetuate middle-class privilege.

For students without access to family financial support, these hidden costs are not just minor inconveniences but major barriers. The Sutton Trust (2023) found that nearly half of all students depend on their families to cover basic living expenses. However, for working-class students, this support is often unavailable. As Jake explained, he had no one to turn to for financial help, and institutional responses failed to address this gap.

The cost-of-living crisis has worsened these inequalities. Inflation, rising rent, and increased energy and food costs have added more pressure on students already struggling financially. The Sutton Trust (2023) reported that 23% of students were skipping meals to manage rising expenses, and 27% had taken on extra work to support themselves. For medical students, whose schedules are already full with study and clinical placements, the ability to take on paid work is highly limited.

These financial pressures have practical consequences: students miss lectures, decline placements, and reduce study time to work. These missed opportunities affect academic performance, mental health, and future career prospects. The emotional exhaustion, anxiety, and shame that accompany financial hardship are compounded by institutional cultures that normalise privilege and fail to recognise class-based disadvantage (Friedman and Laurison, 2019; Reay, 2015).

Conclusion

The emotional, structural, and practical challenges faced by working-class medical students are not isolated incidents but symptoms of a broader system that privileges those with economic and cultural capital. The hidden costs of study, lack of familial financial support, and the intensifying cost of living crisis collectively create a hostile environment for students from disadvantaged backgrounds. These challenges are not simply financial; they are emotional, structural, and deeply embedded in the culture of medical education. Addressing them requires a comprehensive approach that includes financial support, flexible policies, and a commitment to recognising and valuing students' diverse realities. Without such change, the promise of widening participation remains incomplete, offering access without equity, and opportunity without understanding.

Belonging at university

Access to higher education has indeed widened, yet as O’Shea and May (2014:46) note, ‘the welcome can be more difficult to locate’. Belonging in higher education is a vital component of student success, influencing academic engagement, motivation, persistence, and overall achievement. It encompasses more than mere presence in a university setting; it involves feeling connected to peers, staff, and the institution; experiencing safety and inclusion; being recognised and accepted for one’s identity; and participating in an environment that values diversity and fosters inclusive practices.

Yosso’s (2005) framework of community cultural wealth offers a powerful lens for understanding belonging among working-class students. Rather than viewing these students through a deficit model that assumes they lack the cultural capital necessary to succeed, Yosso identifies multiple forms of capital, including aspirational, linguistic, familial, social,

navigational, and resistant, that students from marginalised backgrounds often bring. These forms of capital are not always recognised or valued by institutions, yet they are central to how students navigate and make sense of their academic environments. For example, navigational capital enables students to manoeuvre through unfamiliar and often exclusionary institutional structures. In contrast, familial and resistant capital provide emotional grounding and a sense of purpose rooted in community and social justice. In the context of belonging, Yosso's framework shifts the focus from whether students 'fit in' to whether institutions are willing to adapt and affirm the diverse strengths students already possess. This perspective aligns with Gillen-O'Neal's (2021) findings that a sense of belonging is closely tied to feeling valued and connected within the academic community. When institutions fail to recognise these alternative forms of capital, they risk reinforcing symbolic violence (Bourdieu, 1991) and undermining the very sense of belonging they claim to promote.

Accent Bias and the Hidden Curriculum in Higher Education

Microaggressions, subtle and often unintentional slights or dismissals, are a persistent feature of working-class students' experience in elite academic environments. Although they may seem minor in isolation, their cumulative effect can be deeply damaging, fostering a sustained sense of exclusion and undermining students' confidence and sense of belonging (Walkerdine, 2021; Wyatt et al., 2024; Reay, 2017). Pete, a Year 2 student, reflects on this dynamic:

> I felt resentment towards my gruff northern accent and straightforward way of speaking.

This illustrates how traits valued in many working-class communities, such as directness and authenticity, can be perceived as unprofessional or abrasive in elite academic settings. Such responses reflect broader forms of symbolic violence, in which institutional expectations subtly devalue working-class cultural expressions (Bourdieu, 1990; Skeggs and Loveday, 2012).

The concept of institutional habitus (Reay et al., 2001; Atkinson, 2011) helps explain how these norms operate. Educational institutions often reflect and reproduce middle-class dispositions, shaping expectations around language, behaviour, and self-presentation. Students from working-class backgrounds may therefore experience a conflict between their personal identity and institutional culture, leading them to self-monitor and adapt as they attempt to fit in. This process, while often necessary for academic survival, can come at the cost of authenticity and emotional well-being (Lehmann, 2014; Loveday, 2015).

These pressures are exacerbated by the lack of representation and support structures for working-class students in higher education (Bathmaker, 2018; Soria and Bultmann, 2014). Without visible role models from similar backgrounds, students may internalise the belief that success requires assimilation into dominant cultural norms. This internalisation contributes to the emotional toll of class marginalisation, including feelings of inadequacy, shame, and alienation (Reay, 2017; Hanley, 2019).

Recent research by Crew (2025) highlights the urgency of addressing accent bias in UK universities. Their survey of more than 600 students at a Russell Group institution found that 30 per cent had experienced mockery because of their accent, and 33 per cent feared it would affect their future success. Students from the North of England and those from

working-class backgrounds reported feeling undervalued, reluctant to participate in class, and pressured to modify their speech. These findings demonstrate how accent bias erodes confidence and a sense of belonging, increasing the risk of non-continuation in higher education.

Stephen, a Year 3 student, describes how these dynamics extend beyond peer interactions:

> Having a regional accent does not help, and other students, and sometimes academics, who are not from working-class backgrounds, treat you as less intelligent, even though you are doing the same course

This perception reflects deeper cultural biases within the institution. Linguistic capital, the ability to use language in ways valued by dominant institutions, is unevenly distributed and closely tied to class (Bourdieu, 1986). Students who do not possess the preferred accent or mode of expression are often misrecognised as lacking competence, regardless of their academic performance.

Although widening participation policies aim to broaden access, they often fail to address the cultural and structural inequalities embedded within elite institutions (Bathmaker et al., 2018; O'Sullivan, 2023). Access alone does not equate to inclusion and may instead expose working-class students to environments that privilege middle-class norms of behaviour, communication, and self-presentation. O'Sullivan's (2023) concept of classed exclusion captures this process, in which students are subtly but persistently made to feel out of place. As Reay (2017, p. 125) argues, widening access without cultural change risks becoming a symbolic gesture rather than a transformative practice.

As a result, many working-class students engage in identity negotiation, modifying aspects of their accent, vocabulary, and interpersonal style to align with dominant expectations (Lehmann, 2014; Loveday, 2015). This negotiation is deeply emotional, as students weigh the cost of assimilation against the risk of exclusion. Some suppress elements of their cultural identity to avoid being perceived as unprofessional, while others resist these norms, often experiencing isolation, anxiety, and vulnerability (Hanley, 2019; Rickett and Morris, 2020). The emotional labour involved in this constant self-regulation is substantial and often invisible, yet it has tangible effects on confidence, engagement, and well-being (Reay, 2015; O'Sullivan, 2023).

Belonging in higher education, especially in professional fields like medicine, goes beyond mere presence. It requires recognition and the ability to thrive without sacrificing one's identity. Everyday behaviours, including accent, food preferences, and leisure activities, serve as markers of difference, indicating who is accepted within the cultural fabric of medical education. These behaviours are part of the hidden curriculum, which encompasses the unspoken norms and values that determine belonging (Hafferty, 1988; Michalec, 2011; Jenkins et al., 2021). As O'Shea and May (2017) observe, students must learn to navigate the system without being explicitly taught the rules, often risking their authenticity in the process.

For many working-class students, connecting with peers from similar backgrounds is vital for maintaining authenticity and emotional well-being (Reay, 2005; Loveday, 2015). However, in elite fields like medicine, these students are often few and far between (Bathmaker et al., 2018; Crew, 2025). The absence of shared cultural references can increase feelings of isolation, especially when dominant norms related to lifestyle, language, and social

interactions are unfamiliar or excluded (Addison and Mountford, 2014; Byrom and Lightfoot, 2012).

Josh, a Year 2 student, describes finding connection outside the medical programme:

> I was lucky that in year one, I made friends with some students in my halls. They are not medical students, but we get along. Our term dates are slightly different, and because I am constantly revising, it can be challenging. However, at least I feel included in my flat.

Josh's experience highlights the importance of informal networks in fostering belonging. Nevertheless, many working-class students leave established networks when entering university, particularly when living on campus, which can lead to dislocation from familiar people and cultural practices (Reay et al., 2009; Finnegan and Merrill, 2017).

Tiffany, a Year 5 student, describes the emotional impact of class-based microaggressions:

> I have faced a lot of classism here; some comments from other students have been really hurtful. What is worse is that many don't even see it as a problem. They make fun of accents or where people are from, like working-class backgrounds don't belong here. It is clear they do not realise, or care, that some of us are from those backgrounds.

Her experience illustrates how accent, location, and background can become targets of mockery, reinforcing prevailing stereotypes about who is suited for medicine. The informal nature of these comments and the lack of acknowledgement of their harm highlight a broader culture of misrecognition, in which working-class identities are often viewed as inferior (Reay, 2017; Skeggs, 1997).

Laura, a Year 4 student, similarly notes:

> I do not think I have received any purposely hurtful comments. Plenty of accidental insults and being made to feel inferior, though

This highlights the subtlety of microaggressions. Although they are seldom obvious or intentionally harmful, their effects are significant. Through implication, tone, and repetition, they foster an environment in which working-class students often feel marginalised and undervalued (Cribb and Bignold, 1999; Rickett and Morris, 2020).

Belonging at home.

For working-class students in medical education, the concept of 'home' carries profound emotional, cultural, and psychological significance. It is not merely a place of residence but a vital source of identity, affirmation, and resilience. In contrast to the often alienating, individualised, and class-coded environments of elite medical institutions, home offers a space where students feel understood, valued, and emotionally safe. This sense of safety is not only personal but deeply relational, rooted in community ties, shared histories, and a collective ethic of care (Skeggs, 1997; Gillies, 2005).

Home, for many working-class students, is embedded within tightly knit communities where mutual support, loyalty, and interdependence are central to everyday life. These communities often function as moral economies, where value is not measured by academic credentials or professional status but by one's commitment to others and to collective

wellbeing (Halewood, 2023; Bathmaker et al, 2018). In such contexts, students are not simply individuals pursuing personal advancement; they are representatives of their families and neighbourhoods, carrying with them the hopes, sacrifices, and aspirations of those who may not have had the same opportunities (Reay, 2017; O'Shea and May, 2017).

This relational identity stands in stark contrast to the competitive, individualised ethos of higher education, particularly in medicine, where success is often framed as a solitary achievement (Livesey, 2019; Friedman and Laurison, 2020). For working-class students, the university can feel like a space of misrecognition, where their values, ways of speaking, and relational orientations are not only unfamiliar but actively devalued (Bourdieu, 1990; Reay, 2015). In this context, home becomes a site of resistance and restoration. It is where students can reconnect with a sense of belonging that is not contingent on performance, assimilation, or the adoption of middle-class norms.

Moreover, the emotional pull of home is intensified by the experience of being a minority within the university. As Reay et al. (2009) describe, working-class students in elite institutions often feel like 'strangers in paradise', navigating spaces where they are hyper-visible yet culturally invisible. Being culturally invisible and, arguably, as the evidence shows, having limited confidence can mean that, for many students, university feels far from paradise. A place where personal history conflicts with this new environment can make the institutions' offerings feel inaccessible. Returning home offers a reprieve from this tension, a place where they are not required to explain themselves, justify their presence, or translate their experiences. It is a space of unconditional acceptance, where their worth is affirmed through relationships rather than credentials.

This sense of acceptance is particularly important in medicine, where the hidden curriculum often reinforces hierarchical, gendered, and exclusionary norms (Hafferty, 1988; Michalec, 2011; Jenkins et al, 2021). For students who feel marginalised within clinical and academic settings, home provides a counter-narrative, a reminder that their identity is not defined by institutional standards but by the values and relationships that shaped them. As Yosso (2005) argues, these forms of community and familial capital are not deficits to be overcome but assets to be recognised, nurtured, and valued.

Consequently, home matters more to working-class medical students because it offers what the university often cannot: a sense of continuity, moral grounding, and relational belonging. It is a space where students are not only accepted but affirmed—where their struggles are understood, their achievements celebrated, and their identities sustained. Recognising the centrality of home and community in the lives of working-class students is essential for creating more inclusive and supportive educational environments. This section draws on participants' narratives to challenge the dominant framing of social mobility as escape, arguing instead that acceptance at home is crucial to the successful navigation of medical education.

'A Place Where I am Good Enough': Home as Emotional Anchor in Working-Class Medical Students' Lives

Medical school is widely recognised as a high-pressure environment, but for working-class students, the challenges extend beyond academic rigour. They must also navigate a hidden curriculum (Hafferty, 1988; Michalec, 2011) that favours middle-class norms and values, which often clash with their lived experiences. These unspoken expectations regarding

language, behaviour, and cultural capital shape perceptions of who is seen as a legitimate student and who is perceived as out of place (Lawrence et al., 2018; Jenkins et al., 2021). For many working-class students, this fosters a persistent sense of not fitting in - of being present but not fully recognised.

In this context, home becomes more than a place of rest; it becomes a sanctuary of emotional survival. Chloe (Year 4) shared:

> It may seem small, but in the early days, I went home as much as possible to get reassurance from my mam that I had made the right choice.

Chloe's need for reassurance reflects the emotional vulnerability that often accompanies social mobility. Her return home is not a sign of weakness but a strategy of self-preservation. It is at home that she finds validation for her decision to pursue medicine, a decision that may not always feel secure in an environment where she is made to feel like an outsider. As Reay (2017) notes, working-class students often experience elite institutions as spaces of 'institutional dissonance,' where their presence is tolerated but not fully embraced.

Josie (Year 2) echoed this sentiment:

> The early days of uni were so hard; I was only an hour away from home and went home for as many weekends as I could. At home, I was good enough.

Josie's words highlight the contrast between institutional misrecognition and familial affirmation. While universities often operate through a meritocratic lens that rewards confidence, cultural fluency, and detachment (Friedman and Laurison, 2020), home remains a space where students are valued for who they are rather than how well they perform. This emotional grounding is essential for students who may otherwise feel adrift in unfamiliar academic and social terrain.

Rosie (Year 2) further illustrates the emotional importance of home and connection:

> FaceTime is a lifesaver. When I have felt really stressed and lonely, seeing my mam's face and hearing her voice have kept me going. Sometimes I just need a real conversation, no big words, no competition, just someone to speak to who knows and likes me. Luckily, I have kept in touch with friends from school. Some are at uni in other places, some are working. It doesn't matter, we have known each other for years.

Rosie's account powerfully captures the emotional toll of isolation and the restorative power of familiar relationships. Her longing for 'no big words, no competition' speaks to the performative nature of academic life, particularly in medicine, where students are often expected to adopt a professional persona that may feel alien or inauthentic. Her connection to home and long-standing friendships offers a reprieve from this pressure, a space where she can be herself without fear of judgment or exclusion.

These narratives show that for many working-class students, home is not just a place of comfort but a vital emotional resource that sustains them through the psychological demands of medical education. It provides a stable reference point in a world that demands transformation. As Skeggs (1997) argues, working-class identity is often rooted in moral value, expressed through care, loyalty, and relational responsibility. These values are rarely recognised within the competitive, individualistic culture of medical education (Livesey,

2019), yet they are central to how many working-class students understand themselves and their purpose. Home, then, is not just a retreat from institutional alienation; it is a site of resistance, where students can reconnect with the values that motivated them to enter medicine in the first place.

This emotional and moral anchoring is particularly important in medicine, where the hidden curriculum often reinforces hierarchical and exclusionary norms (Hafferty and Hafler, 2011; Beagan, 2005). For students who feel marginalised within clinical and academic settings, home provides a counter-narrative, a reminder that their identity is not defined by institutional standards but by the relationships and communities that shaped them. As Yosso (2005) argues, these forms of familial and community capital are not deficits to be overcome but assets to be recognised and valued.

Ultimately, the emotional refuge of home is not a peripheral aspect of the working-class medical student experience; it is central to their ability to persist and succeed. Home offers a space of belonging, affirmation, and moral clarity in a system that often demands detachment, assimilation, and emotional suppression. It provides continuity amid cultural dislocation and serves as a vital counterbalance to the pressures of institutional life. Recognising the significance of home in the lives of working-class students is essential to understanding the full scope of their educational journey and to developing more inclusive and responsive support structures within medical education.

Family, Pride, and the Pressures of Representation

For many working-class medical students, family is not only a source of emotional support but also a powerful motivator and moral compass. The values instilled through family and community, care, loyalty, and responsibility form what Yosso (2005) describes as familial capital: a form of cultural wealth rooted in kinship, shared struggle, and collective resilience. These values often stand in contrast to the individualistic ethos of higher education, particularly in medicine, where success is frequently framed as a solitary, merit-based achievement (Friedman and Laurison, 2020; Livesey, 2019; Bathmaker et al, 2018).

Rather than viewing their journey through medical school as a personal triumph alone, many participants framed it as a shared accomplishment, one that honours the sacrifices of their families and communities. This sense of collective pride can be empowering, but it also brings with it a unique set of pressures. Joe (Year 3) reflected on this duality*:*

> People at home are really proud of me. It is a lot of pressure because I cannot explain that sometimes fitting in at uni is so hard. I just want to quit and go home.

Joe's words reveal the emotional complexity of being a symbol of success in a context that often feels alienating. The pride of family members, while deeply affirming, can also become a burden, especially when students feel unable to share the difficulties they face in elite academic environments. As Reay (2017) notes, working-class students often carry the weight of representation, feeling responsible not only for their own success but for validating the aspirations of their entire community. This aligns with the findings of Byrom and Lightfoot (2012), who argue that working-class students often experience their educational journey as a form of 'transgression' rather than transformation, as they navigate unfamiliar cultural expectations while trying to remain connected to their roots.

This burden is compounded when students are expected to perform not just academically, but socially and professionally, often before they feel ready. Natasha (Year 3) described the added pressure she experienced once clinical placements began:

> My mum's friends love telling people they know a doctor, but this also means when they can't get a GP appointment, they ring me instead. They think I am fobbing them off when I advise them to keep trying the GP. Obviously, I would help if I could, but I don't know the answers.

Natasha's experience illustrates how the symbolic status of 'becoming a doctor' can blur the boundaries between student and professional in the eyes of others. Her community's pride in her achievements is palpable, but so too is their expectation that she can already fulfil the role of a doctor. This premature professionalisation places students in a difficult position, caught between wanting to help and recognising the limits of their current knowledge and authority. As Beagan (2005) notes, working-class students in medical school often experience a heightened sense of marginality, not only within the institution but also in their attempts to meet the expectations of those at home.

These expectations are not limited to clinical advice. As Rosie (Year 2) shared earlier, the emotional labour of maintaining relationships with family and friends is intensified by the need to remain grounded and accessible. Rosie's desire for authenticity and connection reflects a broader theme among participants: the need to remain tethered to their roots in the face of institutional pressures to change. As Skeggs (1997) argues, working-class identity is often constructed through moral value, a good daughter, a loyal friend, a caring neighbour. These values are rarely recognised within the formal structures of medical education, yet they are central to how many students understand their role in the world. This echoes the findings of Ingram (2009), who highlights how working-class students often draw on their community-based values as a source of strength and identity in educational spaces that fail to reflect their lived realities.

Recognising these dynamics is crucial for understanding the lived experiences of working-class medical students. Their journeys are not just academic; they are relational, emotional, and deeply embedded in the moral economies of their communities. Supporting these students requires more than financial aid or academic mentoring; it requires an institutional culture that values their backgrounds, understands their burdens, and affirms their right to belong without leaving parts of themselves behind.

More Than a Place: Home as a Political and Emotional Anchor

Despite the tensions and pressures of navigating elite academic environments, home remains a powerful source of resistance for working-class medical students. In a system that often demands assimilation into middle-class norms, through language, behaviour, and professional identity, maintaining ties to home allows students to preserve their cultural identity and sense of self. This is not a retreat but a form of defiance: a refusal to abandon the values, relationships, and routines that have shaped them.

Jack (Year 2) illustrates this quiet but meaningful resistance:

> As much as I can, I go home and watch football with my dad. We meet up with people that we have known for years. It has really helped with my mental health while settling in at uni.

Jack's return to familiar routines, watching football, and reconnecting with long-standing community ties, is not simply about relaxation. It is a deliberate act of staying grounded in a world that often feels unfamiliar and performative. These moments of continuity offer emotional stability and reinforce a sense of identity that is not defined by institutional expectations. In doing so, Jack resists the pressure to conform fully to the cultural codes of medical education, instead asserting that his background and values remain central to who he is becoming.

As Skeggs and Loveday (2012) argue, working-class individuals often engage in 'value struggles,' asserting their worth in systems that misrecognise or undervalue their cultural practices. Returning home, staying connected, and drawing strength from family and community are all ways of resisting the erasure of working-class identity in elite spaces. These acts of resistance are not always visible, but they are deeply political. They challenge the idea that success requires detachment and instead affirm that belonging can be plural, relational, and grounded in care (Skeggs, 1997; Loveday, 2015).

This resistance is particularly significant in medicine, where the hidden curriculum often reinforces hierarchical, gendered, and exclusionary norms (Hafferty, 1988; Lawrence et al, 2018; Michalec, 2011). For working-class students, the pressure to adopt a professional identity that aligns with institutional expectations can feel like a demand to disavow their roots. As Jenkins et al. (2021) note, the formation of professional identity in medical education is often shaped by implicit norms that privilege middle-class dispositions and marginalise alternative ways of being.

Maintaining ties to home, then, becomes a way of asserting continuity in the face of cultural dislocation. It allows students to draw on what Bourdieu (1986) calls 'embodied cultural capital', the values, behaviours, and knowledge acquired through lived experience. These forms of capital may not be recognised within the formal structures of medical education, but they are central to students' sense of self and purpose. As Ingram (2009) and Bathmaker et al. (2018) argue, working-class students often draw on their community-based values as a source of strength and identity in educational spaces that fail to reflect their lived realities.

Moreover, this resistance is not only cultural but emotional. Jack's emphasis on mental health underscores the psychological cost of assimilation. The pressure to adopt a new identity, to speak differently, to behave 'professionally,' can be exhausting and alienating. By returning to a space where he is known and accepted without condition, Jack protects his wellbeing and reaffirms his sense of self. This aligns with Crew's (2025) findings on the mental health challenges faced by working-class academics and students, who often experience emotional strain as they navigate unfamiliar and unsupportive institutional cultures.

In this way, home becomes a site of cultural continuity and emotional resistance. It allows students like Jack to remain connected to the people and practices that give their lives meaning, even as they move through spaces that often demand transformation. Recognising these forms of resistance is essential for understanding the full complexity of working-class students' experiences in medical education, and for challenging the deficit narratives that frame their backgrounds as something to be overcome rather than something to be honoured.

For working-class medical students, home is more than a place, it is a lifeline. It offers emotional stability, cultural affirmation, and moral clarity in a system that often demands transformation, detachment, and conformity to middle-class norms. In the context of medical education, where the hidden curriculum privileges confidence, detachment, and cultural fluency (Hafferty, 1988; Michalec, 2011), home becomes a vital counterbalance. It is a space where students are not required to perform, translate, or justify themselves, a space where they are simply known and accepted.

This chapter has shown that home is not only a source of comfort but also a site of resistance. Participants described returning to familiar routines, maintaining long-standing friendships, and drawing on the moral values instilled by family as essential strategies for preserving their sense of self. These practices challenge the dominant narrative of social mobility as a linear journey of escape, one that assumes success requires leaving behind the people and places that shaped you. Indeed, the idea that upward mobility necessitates a break from one's origins is deeply problematic. It implies that working-class life is something to be transcended, rather than something to be valued. As Reay (2017) and O'Shea and May (2017) argue, this framing not only misrepresents the lived experiences of many students but also reinforces deficit discourses that devalue working-class culture. The participants in this study did not seek to escape their homes, families, or communities. On the contrary, they drew strength from them. Their success in medicine was not despite their background, but because of it.

This tension between the institutional expectation of detachment and the personal need for connection lies at the core of the working-class student experience. It prompts important questions about what we understand as inclusion and success in higher education. If belonging requires assimilation, and if achievement is judged by distance from one's roots, then what kind of success is being offered? Understanding the centrality of home is therefore essential for developing inclusive and responsive support systems in medical education. Rather than viewing familial ties as liabilities or distractions, institutions must recognise them as sources of strength, continuity, and cultural wealth (Yosso, 2005; Skeggs, 1997). This means creating space for students to remain connected to their communities, acknowledging the emotional dimensions of classed experience, and challenging the deficit narratives that frame working-class identity as something to be overcome.

Ultimately, supporting working-class students in medicine requires more than widening access; it requires reimagining belonging. It means recognising that success does not have to come at the cost of identity, and that home, far from being left behind, can be carried forward as a source of pride, resistance, and resilience.

Discussion Chapter 3. Between the Textbook and the Ward: Class, Meaning, and the Making of a Doctor

This chapter examines the lived experiences of working-class medical students within clinical education, highlighting how their backgrounds influence their motivations, mental health, and sense of purpose in the medical field. These students often navigate a professional landscape that is implicitly structured around middle-class norms and expectations, which can lead to feelings of exclusion, misrecognition, and emotional strain.

To set the scene for this discussion, I utilise Pierre Bourdieu's theoretical concepts of habitus, symbolic violence, and cultural capital (Bourdieu, 1984; 1990). These ideas help explain how institutional practices in medical education can marginalise students whose cultural dispositions and values differ from mainstream norms. For instance, the embodied ways in which working-class students show care and empathy might be undervalued or even penalised in clinical environments that emphasise emotional detachment and technical skill.

Skeggs (1997) extends this analysis by showing how working-class identities are often devalued in professional contexts, not because of a lack of ability, but due to a misrecognition of their cultural practices and moral frameworks. This misrecognition can manifest as symbolic violence, subtle, often invisible forms of exclusion that reinforce existing hierarchies. However, rather than viewing working-class students through a deficit lens, this chapter also draws on Yosso's (2005) framework of Community Cultural Wealth to highlight the strengths and assets these students bring to the field of medicine. Yosso identifies forms of capital often overlooked in traditional educational settings, such as navigational capital, resistant capital, and aspirational capital. These forms of capital help explain how working-class trainees persist, adapt, and thrive despite the systemic barriers they face. Their lived experiences often foster resilience, empathy, and a deep understanding of patient hardship, qualities that are essential to compassionate and equitable healthcare.

The relevance of this analysis is particularly acute in the context of widening participation in medical education. While policies have aimed to increase access for students from underrepresented backgrounds, structural inequalities persist (Baxter et al, 2015; Boursicot and Roberts, 2009). These inequalities are not only material but also cultural and emotional, shaping how students experience belonging, success, and professional identity. By centring the voices of working-class students, this chapter seeks to challenge dominant narratives of professionalism and care in medicine. It argues for a more inclusive understanding of what it means to be a 'good doctor', one that values relationality, empathy, and authenticity alongside clinical expertise.

Becoming the Right Kind of Doctor: Class, Conformity, and the Hidden Curriculum in Clinical Spaces

The clinical environment is a powerful site of socialisation, where medical students not only learn technical skills but also absorb the profession's cultural norms. For working-class students, this space often feels alien and exclusionary. The challenge is not merely academic but cultural: to 'fit in' with peers and professionals whose behaviours, values, and assumptions are shaped by middle-class norms. These norms are rarely made explicit, yet they are enforced through subtle cues and expectations that can leave working-class students feeling out of place, inadequate, or invisible.

Tiffany (year 5) described this discord in a moment that, while seemingly mundane, reveals the depth of cultural misalignment:

> Placements are challenging... It's things like when I am eating a burger, and they are eating something with pesto, and they look at me, I know I am doing something wrong, but I don't understand why.

This moment captures the embodied nature of class difference. The student is not explicitly excluded, but their feeling of being ‘wrong’ shows how deeply classed norms are built into the clinical environment. As Gillies (2005) and Skeggs (1997) have demonstrated, working-class practices are often seen as deficient or inappropriate, even when they are morally and emotionally rich.

James (Year 4) offered a further example of cultural misalignment:

> The rest room is difficult to feel involved – they are going to the dry slopes to practice for a holiday, or going to play tennis. These sports are not something I had ever considered.

Here, leisure becomes a form of distinction (Bourdieu, 1984). Participation in certain activities signals belonging, while unfamiliarity marks someone as an outsider. These exclusions are not about competence but about cultural capital, knowing the right codes, references, and behaviours. Arguably, playing a particular type of sport does not affect patient care, but feeling excluded from the norms of clinical social life can be isolating.

Leon (Year 3) articulated the emotional cost of this exclusion:

> Placements are difficult, not clinically; I have worked hard to be competent in my knowledge, but as one of the few working-class trainees, it can be very isolating. The only thing I have in common with them is the patients.

Leon’s comment is particularly insightful. His identification with patients, rather than peers or supervisors, reflects a deeper alignment of values and experiences. It also underscores the relational capital that working-class students contribute to medicine, an ability to connect with patients not just as cases, but as individuals. This is a form of cultural wealth that Yosso (2005) describes as navigational and resistant capital: the ability to endure in hostile environments and to challenge dominant norms through lived experience.

However, this capital is rarely recognised within the formal structures of medical education. As Jenkins et al. (2021) and Michalec (2011) observe, the hidden curriculum often rewards emotional detachment, technical fluency, and cultural conformity. Students who do not, or cannot, follow these norms risk being seen as unprofessional, even if their patient care is outstanding. Ultimately, the pressure to conform creates a constant negotiation between authenticity and assimilation (Reay, 2017). Students must weigh the cost of staying true to their background against the benefits of being accepted by the institution. This negotiation is not just intellectual; it is emotional, embodied, and exhausting. It is about learning to speak, dress, and even feel differently to be seen as the ‘right kind of doctor’ (Friedman and Laurison, 2019).

Despite these challenges, working-class students demonstrate extraordinary strength. They draw on their community cultural wealth (Yosso, 2005), their lived experiences, and their moral commitment to care. But their success should not depend on their ability to adapt to a system that was not designed for them. Instead, medical education must begin to value the diverse forms of knowledge, empathy, and care that these students bring.

Electives and Exclusion: Economic Capital and the Illusion of Choice

Although medical education aims to be meritocratic, the structure of clinical training often favours those with access to financial resources. This is especially clear in the system of electives, which are presented as accessible to everyone but are actually only reachable for some. For working-class students, the financial and logistical challenges of electives can be overwhelming, deepening feelings of exclusion, inadequacy, and inferiority.

Several participants in this study described the emotional impact of being unable to participate in overseas electives. Meg (Year 4) reflected:

> We have electives, and as a student, how can you afford to live overseas for a month? Like, there are grants and stuff, but they definitely don't cover everything. For someone like me, this is just not an option; I need to stay close to my accommodation and go to work. It makes me feel poor – I'm not poor, I am doing okay.

Meg's reflection highlights the tension between financial stability and professional growth. While she manages her circumstances, the structure of electives makes her appear lacking. This is not just about money; it also involves the symbolic value linked to certain experiences. As Bourdieu (1986) argues, economic capital often transforms into symbolic capital, granting prestige and legitimacy to those able to participate fully.

James (Year 4) echoed this sentiment:

> The electives noticeboard for me is a list of amazing places and opportunities that I will not be able to access.

The electives noticeboard was mentioned frequently by the participants and for many of them represents a symbol of exclusion, a visual reminder of what is out of reach.

These experiences are not isolated. Lily (Year 5) shared:

> When people tell me they are going somewhere exotic like America for a placement, and I am trying my best to stay in a commutable distance, I don't just feel poor, I feel inferior.

Lily's words reveal the emotional weight of exclusion. The issue is not just logistical; it is deeply tied to identity and self-worth. As Reay (2006) and Hanley (2019) argue, working-class students often internalise these exclusions, leading to feelings of shame and inadequacy even when they are succeeding academically. These reflections challenge the narrative that all students have equal access to opportunity. As Sointu (2020) and O'Sullivan (2023) note, the rhetoric of choice in higher education often masks structural inequalities. Electives are presented as optional, but tin reality, they function as markers of distinction, signalling ambition and cultural capital.

Evidently, the expectation that students will undertake unpaid or underfunded placements assumes a level of financial security that many lack. This assumption reflects what Skeggs calls the 'moral economy of personhood' (1997:99), a system where value is assigned not only to what one does but also to how one can do it. Those unable to afford participation are

not only excluded; they are also subtly devalued, with their choices seen as personal limitations rather than structural constraints.

In response, working-class students must draw on what Yosso (2005) describes as aspirational and navigational capital, the ability to maintain hope and find alternative routes through systems that were not designed for them. However, this resilience should not be romanticised. As Hafferty (1988) and Michalec (2011) argue, the hidden curriculum transmits unspoken expectations about what constitutes a successful medical student. These expectations often align with middle-class norms of flexibility, mobility, and financial independence, norms that are inaccessible to many working-class students. Consequently, the structure of medical education reproduces inequality under the guise of meritocracy (Boursicot and Roberts, 2009; Coyle et al, 2021).

These forms of capital are potent, but they are also emotionally and physically exhausting. Nicole (Year 4) captured this burden succinctly:

> What am I doing at the weekend? My washing and revising for assessments.

Nicole's comment subtly criticises a system that privileges some while demanding sacrifices from those with little to give. Her experience highlights not only economic inequality but also the emotional strain of navigating a space that fails to recognise her reality. This echoes what Loveday (2015:1147) describes as the 'affective burden' of classed participation in higher education, the emotional labour involved in constantly managing visibility, legitimacy, and self-worth in an environment that does not acknowledge or value working-class constraints. This burden is not merely about fitting in; it is about surviving in a system that subtly devalues the cultural and emotional resources that working-class students bring. The effort to stay composed, competent, and credible while bearing this invisible weight is a form of labour that is often overlooked, yet it significantly influences students' experiences of belonging and achievement.

The Professional Culture of Medicine: Class, Belonging, and Expected Nepotism

The professional culture of medicine is often portrayed as an impartial, merit-based environment guided by shared values of excellence, responsibility, and scientific rigour. However, for many working-class students, this culture can feel isolating, exclusionary, and subtly influenced by class-specific expectations. The norms of behaviour, language, and social interaction within medical settings often reflect middle- and upper-class customs, making it difficult for individuals from diverse backgrounds to feel a sense of belonging (Freidman and Laurison, 2019; Reay, 2017).

Callum, a fifth-year student, recounts an experience that illustrates this lack of belonging:

> The social side of medicine can be difficult; I struggle to fit! For example, one of the consultants invited me to their birthday party at their home. How lovely I thought, everyone was so dressed up and the entertainment a bloody string quartet. The guests were discussing the music, I had no clue. Parties for me have always been a DJ with karaoke. I felt like I was in another world.

Callum's narrative highlights the symbolic boundaries that structure professional social life in medicine. His discomfort is not due to overt exclusion, but to a more subtle form of cultural

misrecognition, a sense that his own social and cultural references are out of place in elite medical settings. This reflects Bourdieu's (1984) concept of distinction, in which cultural tastes and practices serve as markers of class and tools of symbolic exclusion. The string quartet is not just entertainment; it is a signal of belonging, a performance of cultural capital that Callum feels excluded from.

This experience also illustrates the persistence of what Reay et al. (2009) describe as the 'stranger in paradise' effect, where working-class students in elite institutions feel like outsiders, even when they are academically successful. The discomfort Callum describes is not simply social; it is epistemological in nature. It challenges the assumption that medicine is a culturally neutral profession, revealing how classed norms shape who feels at home in its spaces.

Meg, a fourth-year student, offers another perspective on how class shapes perceptions of legitimacy and aspiration:

> When I said I wanted to be an anaesthetist, people assumed that was my parents' speciality. My dad works for the council, and my mum works in a school, but many of my peers have parents who are doctors, and they often follow in their parents' footsteps.

Meg's account speaks to the phenomenon of expected nepotism, the assumption that success in medicine is often inherited rather than earned. This reflects broader patterns of social reproduction in elite professions, where access to networks, cultural familiarity, and institutional knowledge are passed down through families (Ball et al, 2002; Friedman and Laurison, 2020). For students like Meg, whose aspirations are not backed by familial capital in medicine, these assumptions can be both invalidating and demoralising. Moreover, the idea that a working-class person would progress without working hard it for it is against their culture

The assumption that Meg's career choice must be inherited also reflects what Bourdieu (1986) terms social capital, the resources and advantages that come from being embedded in privileged networks. In medicine, these networks often begin before university, through family connections, school placements, and informal mentoring. As Nicholson and Cleland (2017) argue, access to these forms of capital can significantly shape students' confidence, career choices, and sense of belonging.

Moreover, these experiences are not isolated. They reflect a broader culture in which working-class students must constantly navigate what Ingram (2009) calls the misrecognition of working-class culture, where their ways of speaking, dressing, and socialising are subtly devalued or rendered invisible. This misrecognition is not just a matter of discomfort; it is a form of symbolic violence that undermines students' confidence and reinforces the idea that they do not fully belong.

Yet, as Yosso (2005) reminds us, these students also bring with them community cultural wealth, forms of capital that are often unrecognised by dominant institutions but are vital for resilience, empathy, and innovation. Callum's ability to reflect critically on his experience, and Meg's determination to pursue a speciality despite assumptions, are examples of resistant and aspirational capital in action. These are not deficits to be overcome, but strengths to be valued.

Classed Belonging and the Reframing of Professional Identity

Lily, a fifth-year student, offers a candid reflection on her place within the medical profession:

> I know I am not naturally doctor material, and that's okay. Some colleagues are nice, some are not. I stick with the nice ones, the nurses and my family. I didn't want to be a doctor to take up skiing, I wanted to help patients, all patients.

Lily's words speak to a profound sense of classed self-awareness, a recognition that the dominant image of the doctor does not reflect her own identity or motivations. Her statement, 'I am not naturally doctor material', reflects the internalisation of a professional archetype that is implicitly middle-class, confident, and culturally fluent. Yet rather than seeing this as a deficit, Lily reframes it as a strength: her commitment to care is rooted not in prestige or lifestyle, but in purpose. This reframing aligns with Skeggs' (1997) analysis of respectability and value practices among working-class women, in which moral worth is constructed through care, responsibility, and relational labour rather than through institutional status. Lily's emphasis on helping 'all patients' challenges the meritocratic and often individualistic ethos of medicine, offering instead a collectivist, inclusive vision of care.

Her preference for the company of 'the nice ones, the nurses and my family' also reflects a form of relational resistance. Rather than striving to assimilate into elite professional networks, Lily builds solidarity with those who share her values and emotional orientation. This echoes Rickett and Morris (2020), who describe how working-class academics form affective alliances to survive and resist exclusionary institutional cultures.

Lily's rejection of the symbolic trappings of elite medicine; 'I didn't want to be a doctor to take up skiing', also critiques the aspirational culture that surrounds the profession. As Friedman and Laurison (2020: 89) argue, elite professions often reward not just competence but cultural fit, privileging those who can perform the right kind of middle-class identity. This dynamic mirrors the moral logic of the 'good patient' described by Sointu (2017: 12), where patients who conform to institutional expectations are seen as deserving, while those who do not are subtly devalued. Similarly, students who align with dominant norms of professionalism are more readily recognised as 'real doctors', while those who do not must work harder to prove their legitimacy (Beagan, 2005).

These judgments are not neutral; they reflect what Bourdieu (1984) terms symbolic violence, the imposition of dominant cultural norms that marginalise those who do not conform. Lily's narrative, like those of Callum and Meg, reveals how working-class students must navigate these norms while holding onto their own values and motivations. By drawing on Yosso's (2005) framework of community cultural wealth, we can see Lily's stance as an expression of aspirational and familial capital, forms of strength rooted in lived experience and relational care. Her presence in medicine challenges the profession to broaden its definitions of competence and success, recognising that care, humility, and authenticity are not signs of weakness, but essential contributions to a more inclusive and socially responsive healthcare system.

Language, Legitimacy, and the Misrecognition of Care

In clinical education, the concept of professionalism is often narrowly defined through middle-class norms of speech, behaviour, and emotional restraint. These norms are embedded in what Bourdieu (1984) describes as the dominant habitus, an internalised system of dispositions that shapes what is seen as legitimate, appropriate, and valuable. For

working-class students, whose communicative styles and emotional expressions are shaped by diverse cultural contexts, this can lead to misrecognition: their ways of caring are not only misunderstood but actively penalised.

Alex (Year 3) recounted a moment during placement that illustrates this tension:

> During one placement, I got told off for calling a patient ‘pet’. Where I’m from, that’s a term of endearment that says we care. As a doctor, it is considered unprofessional. But don’t our patients need to know we care? The patient was happy to be called pet.

Alex’s use of 'pet', a culturally embedded expression of warmth, was not recognised as a valid form of patient engagement. Instead, it was reprimanded, exemplifying how symbolic violence (Bourdieu, 1991; Skeggs and Loveday, 2012) operates within medical education to enforce conformity to dominant, middle-class norms. These norms are often presented as neutral standards of professionalism, yet they subtly penalise expressions of care that deviate from institutional standards and expectations.

This experience is not isolated. Lily (Year 5) reflected on the contradiction between being taught to maintain professional distance and the need to understand patients:

> We are told we are doctors, not carers, and we cannot get too close to patients. Surely understanding patients means we can adapt their care.

Nicole (Year 4) also expressed frustration at the lack of empathy she observed among colleagues:

> Of course, we need professional distance, but I have heard colleagues be nasty about patients. Of course, it must be the patient's choice to be sick. These colleagues are supposed to be clever, but it is so annoying.

These reflections highlight how working-class students often feel torn between their natural, relational approach to care and the institutional expectation of emotional detachment. As Reay (2015) and Loveday (2015) suggest, such disciplinary responses mirror a wider devaluation of working-class cultural practices, in which authenticity and emotional expression are misconstrued as unprofessional. This is intensified by what Loveday terms the 'affective burden' (2015:114), the emotional labour required to manage legitimacy and self-worth in a space that fails to recognise or value working-class ways of being.

This tension is further reinforced by the hidden curriculum, which, as Hafferty (1988), Michalec (2011), and Hopkins et al. (2016) note, rewards conformity and emotional neutrality over relational competence. The result is a professional culture that rhetorically endorses patient-centred care while practically undermining it. Reay (2017:108) observes that 'there is a fragile balance between realising potential and maintaining a sense of authenticity'. For many working-class students, authenticity is not simply a personal preference; it is a moral and cultural imperative. Pride in doing a good job, in caring well, and in remaining true to one’s values is deeply embedded in their habitus and forms part of their navigational capital (Yosso, 2005; Balmer et al, 2017).

These students bring a rich understanding of diverse patient backgrounds, often informed by their own lived experiences. Crucially, failure to recognise lived experience has broader implications for health equity. As Marmot (2010) argues, health inequalities are driven by social determinants, conditions shaped by power, resources, and opportunity. Working-class

students, by their lived experience, are often more attuned to these determinants. They understand, for example, that a patient's non-compliance may stem not from ignorance or defiance, but from poverty, housing insecurity, or food scarcity. Their capacity to recognise and respond to these realities is not a deficit but a vital asset in addressing the structural roots of health inequality.

However, as Marmot (2020) warns, the medical profession often fails to engage with these structural dimensions, focusing instead on individual responsibility. By marginalising the voices of working-class students, medical education risks reproducing the very inequalities it seeks to address. If these students were supported and valued, they could help reorient the profession toward a more socially responsive model of care, one that recognises the moral and political dimensions of health.

Structural Competence and the Value of Lived Experience

Working-class students often enter medical education with a deep, embodied understanding of the social determinants of health, knowledge that is rarely acknowledged within the formal curriculum. Their lived experiences give them a relational understanding of hardship, which allows them to recognise the structural barriers many patients encounter. This insight is not only valuable; it is vital for developing a more equitable healthcare system.

Nicole (Year 4) recounted a moment during a hospital placement that illustrates this awareness:

> I heard a doctor get upset with a regular patient on the ward for not using their nebuliser at home. They couldn't understand that the patient did not always have electricity to run it.

Nicole's observation highlights a critical gap in clinical understanding, one that working-class students are uniquely positioned to fill. As Marmot (2010) argues, health inequalities are shaped by the conditions in which people are born, grow, live, work, and age. When these conditions are ignored, healthcare becomes not only ineffective but also unjust.

James (Year 4) articulated this frustration clearly:

> We need more doctors from working-class backgrounds. The number of doctors who cannot or simply do not understand how some patients have to live and why they cannot just adopt a perfectly healthy lifestyle to stop being ill is infuriating.

Lily (Year 5) echoed this sentiment:

> I have a genuine belief that doctors who have lived the worries of money, know that healthy choices are not available to everyone. People have to eat what they have available, cannot have the mould in their house treated or cannot afford their prescription – these are society's failings, not patient choice.

These reflections challenge the dominant narrative of individual responsibility in health. As Sointu (2017) argues, medical education often reinforces a binary logic of the 'good' patient, compliant, informed, and responsible, versus the 'bad' patient, non-compliant, complex, and morally suspect. This framing obscures the structural constraints that influence patient behaviour and perpetuates deficit-based assumptions. Working-class students, through their own experiences of precarity, are more inclined to question these assumptions and advocate for more compassionate, context-sensitive care. Furthermore, Sointu (2020) suggests that

medical students themselves internalise these neoliberal logics, learning to view health through the perspective of personal choice rather than structural inequality. This not only distorts their understanding of patients but also influences their professional identity in ways that can be emotionally distancing. For working-class students, whose habitus is often connected with relational and empathetic forms of care, this results in significant dissonance (Reay, 2015; Loveday, 2015).

Despite their potential to improve health equity, these students often find their insights marginalised. The hidden curriculum continues to prioritise biomedical knowledge and technical skills over structural competence and relational understanding (Lawrence et al., 2018; Jenkins et al., 2021). This not only limits the development of socially responsive doctors but also perpetuates a model of care that is blind to inequality. To realise the transformative potential of working-class students, medical education must move beyond superficial inclusion. It must structurally support and pedagogically embed the value of lived experience. As Marmot (2010) emphasises, addressing health inequalities requires a shift from treating illness to tackling its root causes. Working-class students are not just capable of making this shift; they are already doing it.

Class, Care, and the Emotional Labour of Patient Care

Medical education is often structured around a binary: the scientific and the emotional, the objective and the subjective, the clinical and the personal. For working-class students, this binary is not only artificial but deeply alienating. Their lived experiences, shaped by values of care, solidarity, and emotional connectedness, often clash with the dominant norms of medical professionalism, which privilege detachment, neutrality, and technical mastery. This section explores how working-class students navigate this terrain, and how their narratives reveal a richer, more humane understanding of what it means to care.

James, a fourth-year student, recalls his first rectal examination:

> Pride and dignity are so important to working-class people. My first rectal examination was on an elderly man. I was embarrassed, but I knew he felt worse. He needed reassurance and kindness, not just science.

James's discomfort is not with the procedure itself, but with the emotional and ethical implications of performing it on a vulnerable patient. His response reflects a form of embodied ethics; a moral orientation grounded in his own classed understanding of dignity and respect. This aligns with Hochschild's (2003) concept of emotional labour, where workers manage their own emotions to support others, often in ways that are invisible and undervalued. In James's case, this labour is not only emotional but also cultural: he is translating his values into a clinical context that often fails to recognise them.

This tension is reinforced by the hidden curriculum of medical education, which implicitly teaches students to suppress empathy in favour of clinical detachment (Hafferty, 1988; Lawrence et al, 2018). For working-class students, whose habitus is shaped by relational and affective practices (Reay, 2015; Loveday, 2015), this can create a profound sense of misrecognition. Their ways of knowing and caring are not only unacknowledged but actively devalued, a form of symbolic violence (Bourdieu, 1994) that reinforces the cultural dominance of middle-class norms.

Lily, a fifth-year student, articulates this dissonance:

> I don’t understand how we can treat patients without caring whether we are doing our best and treating them like people.

Lily’s reflection challenges the institutional logic that equates professionalism with emotional distance. Her insistence that understanding patients enhances care reflects a more holistic model of medicine, one that values relationality as a form of clinical competence. This resonates with Beagan’s (2005) findings that working-class students often resist depersonalising patients, drawing instead on their own experiences to foster empathy and connection.

Callum, another fifth-year student, offers a vivid example of this relational approach:

> One patient stands out for me, a 75-year-old retired taxi driver. His wife of 50 years died the previous year; he had malnutrition and was struggling with loneliness. He needed feeding, building up and some company. He reminded me of my grandad. How are we supposed to detach and just treat the illness?

Callum’s narrative demonstrates a keen awareness of social determinants of health—the structural factors that influence health outcomes, such as bereavement, isolation, and poverty (Marmot, 2010; 2020). His response is not just emotional; it is diagnostic. He understands that the patient’s malnutrition is not merely a medical issue but a sign of broader social suffering. This shows a form of structural competence (Metzl and Hansen, 2014), which develops not through formal teaching but through lived experience.

These students’ insights are not anomalies; they exemplify what Yosso (2005) calls community cultural wealth. This framework challenges deficit models of working-class students by emphasising the types of capital they bring to educational environments. James’s and Callum’s emotional recognition reflects familial capital—the cultural knowledge and values passed down through generations. Lily’s critique of institutional norms highlights navigational capital, the skill to traverse and challenge systems not designed for her. Nicole’s frustration with the moralising of illness represents resistant capital, a refusal to accept dominant narratives that personalise blame and obscure structural injustice.

Nicole, a fourth-year student, expresses this resistance clearly:

> Of course, we need professional distance, but I have heard colleagues be nasty about patients. Of course, it must be the patient's choice to be sick. These colleagues are supposed to be clever, and it is so annoying.

Nicole’s critique uncovers the neoliberal logic that frames illness as a matter of personal responsibility. This logic not only distorts clinical judgment but also exacerbates health inequalities by ignoring the structural conditions that shape people’s lives. Her indignation reflects a deeper understanding of health as socially constructed, a perspective often missing from the biomedical model. Together, these narratives show that working-class students are not merely adapting to medical education; they are actively reshaping it. Their emotional labour, far from being a liability, is a form of symbolic resistance (Skeggs and Loveday, 2012) that challenges narrow definitions of competence and professionalism.

Working-class students bring to medicine a form of relational intelligence that is vital for addressing the complex, socially embedded nature of illness. Moreover, their presence in medicine is not just about representation; it is a catalyst for transformation. By prioritising care, dignity, and structural awareness, these students present a vision of healthcare that is

more equitable, compassionate, and responsive to patients' real lives. Their contributions should not be marginalised but embraced as essential to the profession's future.

This section explored how working-class medical students navigate the emotional and ethical complexities of patient examination, often in tension with the dominant norms of detachment and objectivity. Their narratives reveal a form of care that is not only emotional but deeply political, rooted in lived experience, classed values, and a relational understanding of health. This section expands on that analysis by situating these narratives within broader sociological debates about the social life of clinical practice, the structural determinants of health, and the transformative potential of working-class presence in the medical field.

The Social Life of Illness: Seeing Beyond the Symptom

Callum's account in the previous section, of the elderly patient suffering from malnutrition and loneliness, is not just a story of compassion; it is a critique of the biomedical model's limitations:

> He reminded me of my grandad. How are we supposed to detach and just treat the illness?

This question addresses the core of what Frank (2013) refers to as the narrative turn in medicine: the idea that illness is not just a biological event but also a social and existential experience. Callum's understanding of the patient's grief, isolation, and nutritional neglect demonstrates a form of clinical storytelling that is often missing from formal training. His capacity to 'see' the patient within their full social context is not a departure from medical professionalism; it is an enlargement of it. This view aligns with Potter et al. (2018), who argue that effective care for patients with long-term conditions necessitates attention to the 'context of coping', the social, emotional, and economic realities influencing health behaviours.

Working-class students, through their own experiences of precarity, often display a heightened sensitivity to these contexts. Their care is not abstract; it is rooted in recognition, solidarity, and shared vulnerability. This echoes Beagan's (2005) findings that students from marginalised backgrounds frequently adopt a more holistic, socially aware approach to patient care. While structural competence is increasingly discussed in medical education (Metzl and Hansen, 2014), it is often presented as an abstract concept rather than a lived practice. For students like Nicole, however, structural awareness is not just theoretical; it is instinctive. Nicole's frustration reveals a critical awareness of how neoliberal ideologies have permeated clinical discourse, framing illness as a personal failing rather than a matter of structural injustice. Her critique aligns with Dorling (2014) and Scrambler (2018), who contend that austerity and inequality are not merely economic conditions but moral narratives that shape our judgments of the sick and the poor. It also echoes Sointu (2017), who emphasises how clinical training can reinforce inequality by moralising illness and obscuring its social origins.

In this context, working-class students serve as critical witnesses to the system's failures. Their lived experiences provide them with what Yosso (2005) calls resistant capital, the ability to challenge dominant ideologies and advocate for more just and compassionate forms of care. This resistance is not oppositional but generative, creating new possibilities for what medicine can become.

The emotional labour carried out by working-class students is not just a coping mechanism; it is a form of situated knowledge (Haraway, 1988). As Reay (2015) and Loveday (2015) argue, working-class students often experience a cleft habitus, a disjuncture between their embodied values and the institutional norms of elite education. Yet, this disjuncture can also serve as a site of insight. It enables students to recognise what others overlook: the moral injuries of detachment, the violence of misrecognition, and the humanity behind diagnoses.

James's reflection on his first rectal examination is a case in point:

> He needed reassurance and kindness, not just science.

This is not a rejection of science but a call for its humanisation. James's insight challenges the medical model of care and reclaims medicine as a relational practice. His emotional labour is not a distraction from clinical competence; it is a form of affective expertise that enhances it. This aligns with the work of Underman (2020), who argues that emotional engagement is not antithetical to professionalism but central to it.

Reimagining Professionalism Through Classed Lenses

The prevailing model of professionalism in medicine is based on ideals of neutrality, control, and emotional restraint. However, as shown by Michalec (2011) and Jenkins et al. (2021), this model often conceals deeper inequalities, favouring those who can enact detachment over those who feel compelled to care. For working-class students, this form of performance is not only challenging but also ethically complex.

Lily's reflection captures this tension:

> Surely understanding patients means we can adapt their care.

Her statement redefines professionalism not as distance but as adaptability, responsiveness, and relational intelligence. This presents a significantly different view of what it means to be a doctor, one that values empathy as a method, care as critique, and emotion as evidence. It also reflects what Balmer et al. (2017) describe as the importance of community and resourcefulness in shaping medical identity, especially for students from non-traditional backgrounds. The stories of James, Lily, Nicole, and Callum show that working-class students are not just surviving medical education; they are transforming it. Their emotional labour, structural understanding, and relational ethics form a strong type of counter-professionalism that questions the current system and points to a more humane, fair, and socially aware model of care.

To honour these contributions, medical education must move beyond tokenistic inclusion and embrace the full spectrum of what working-class students bring. This means embedding structural competence not just in the curriculum but in the culture of medicine. It means recognising emotional labour as a legitimate form of professional knowledge. And it means reimagining professionalism not as detachment, but as connection.

In short, it means recognising that medicine is not only a scientific discipline, but a deeply social and moral practice, one that is enriched by the lived experiences, values, and insights of those who have long been marginalised within its community.

Lived Experience as Clinical Insight: Reclaiming the Value of Relational Care

As this chapter has shown, working-class medical students bring with them a wealth of insight shaped by lived experience, emotional and cultural humility. These qualities are not only personally meaningful—they are professionally transformative. The following reflections from Josie, Leon, and Nicole offer a powerful closing lens through which to understand the unique contributions of these students.

> I think I want to specialise in psychiatry, it is an advantage to have experienced bad things first hand to understand, rather than just learning from a textbook, Josie, (year 2)

Josie's comment challenges the traditional hierarchy of knowledge in medicine, which privileges textbook learning and clinical detachment. Her insight reflects Haraway's (1988) concept of situated knowledge, which understands that knowledge emerges from embodied experience. In psychiatry, where empathy, trust, and emotional resonance are central to care, Josie's lived experience constitutes a form of epistemic authority. It is not a deficit to be overcome but a strength to be recognised.

> I think my class background, my upbringing, grounds me and makes me more relatable to patients Leon, (year 3).

Leon's reflection highlights the relational capital that working-class students bring to medicine. His sense of groundedness is not incidental; it is cultivated through a habitus shaped by community, humility, and shared struggle. As Bourdieu (1990) suggests, habitus is not only a product of social conditions but also a way of navigating them. Leon's ability to relate to patients is a direct result of his classed experience, enabling him to meet patients not from a position of authority but from one of solidarity.

> A patient said they felt comfortable with me because I am down-to-earth and easy to talk to. She was an end-of-life patient, and it made me cry to think that I had made her feel comfortable - Nicole, (year 5).

Nicole's story is a profound reminder that care is not only clinical; it is also emotional, relational, and deeply human. Her patient's comfort stemmed not from technical skill alone but from presence, humility, and emotional availability. Nicole's tears are not a sign of weakness; they are a testament to the emotional labour that working-class students perform, often invisibly, in the service of compassionate care (Hochschild, 2003; Loveday, 2015).

Together, these reflections reinforce the chapter's central argument: that working-class students are not only capable of becoming doctors but are also redefining what it means to be one. Their insights challenge the profession to move beyond narrow definitions of competence and to embrace a model of care that is relational, reflexive, and rooted in lived experience.

This chapter has traced the lived experiences of working-class medical students as they navigate the clinical, cultural, and emotional terrain of medical education. Their stories reveal a profession shaped not only by scientific knowledge and technical skill, but by deeply embedded classed norms that define who belongs, who succeeds, and what it means to be a 'real' doctor. Drawing on Bourdieu's concepts of habitus, symbolic violence, and cultural

capital, we have seen how the hidden curriculum of medicine privileges middle-class dispositions, confidence, cultural fluency, and emotional restraint, while marginalising the relational, embodied, and often emotionally expressive practices of working-class students. These students are not only expected to master clinical knowledge, but to perform unfamiliar social scripts, often at great emotional cost.

The chapter has also shown how working-class students bring with them a wealth of community cultural capital (Yosso, 2005): relational intelligence, structural awareness, and a deep moral commitment to care. These are not deficits to be overcome, but assets that challenge the narrow definitions of professionalism embedded in medical training. Their ability to connect with patients, to recognise the social determinants of health, and to resist the moralising logic of the 'good patient' (Sointu, 2017) positions them as critical agents of change within the profession. However, these contributions are often misrecognised. As Meg's account of anticipated nepotism illustrates, working-class students are frequently assumed to have succeeded through connections they do not possess. This assumption is not only inaccurate but also deeply contradictory to working-class values of hard work, pride, and self-reliance. In working-class culture, success is earned, not inherited. The idea that one might advance without effort is not only alien but morally suspect. As Skeggs (1997) and Gillies (2005) argue, working-class identities are built around moral worth, responsibility, and the dignity of labour. To suggest otherwise is to undermine the very ethic that drives these students' pursuit of medicine.

This chapter calls for a reimagining of medical professionalism, one that values authenticity, care, and structural competence alongside clinical expertise. Working-class students are not merely adapting to medicine; they are reshaping it. Their presence challenges the profession to broaden its definitions of success and to build a healthcare system that is not only scientifically rigorous but also socially just, emotionally intelligent, and morally grounded.

Medical Trailblazers – working-class students' experiences of becoming a doctor

This thesis has explored the lived experiences of working-class medical students in the UK, focusing on how class identity influences access, belonging, and professional development within elite educational and clinical settings. Using a qualitative mixed-methods approach, grounded in Bourdieu's theory of social reproduction and Yosso's Community Cultural Wealth framework, the study uncovered the structural, cultural, and emotional barriers that continue to shape medical education. These include class-based admissions processes, the hidden curriculum, and the symbolic violence embedded in institutional norms. Despite these challenges, students showed remarkable adaptability, determination, and critical insight. They drew on a wide range of cultural resources, such as family support, moral commitment, and navigational strategies, to persist in environments not designed for them. Their experiences highlight the persistent inequalities within medical education and demonstrate the transformative potential of working-class students to challenge prevailing narratives, reframe professionalism, and incorporate relational, community-rooted values into clinical practice.

Access Without Belonging

Although widening participation initiatives have increased the number of working-class students entering medical school, this research demonstrates that access does not equate to inclusion. Participants repeatedly described feeling like 'outsiders on the inside,' navigating institutional cultures that were not only unfamiliar but often implicitly exclusionary. The symbolic opening of doors to medicine did not dismantle the cultural and structural hierarchies embedded within the profession. The admissions process itself was experienced as a significant barrier. The UCAT, for example, was described by participants as a source of financial and emotional stress. Pete, a second-year student, shared how he had to apply for a bursary to afford the test, waiting anxiously for weeks while also working to support his household. This experience was not unique. Many participants noted that while bursaries existed, the application process itself was a hurdle, one that middle-class applicants were less likely to face.

Moreover, the interview stage was perceived as classed and culturally coded. Participants like Sophie recalled being advised by school staff to consider nursing rather than medicine, based on assumptions about their background and financial situation. This reflects a broader pattern of institutional gatekeeping, where working-class students are subtly steered away from elite professions through lowered expectations and deficit-based assumptions. Even after gaining admission, students encountered a hidden curriculum that reinforced middle-class norms. They described feeling out of place in environments where confidence, fluency in professional discourse, and familiarity with institutional expectations were taken for granted. Jack, a former foundation year student, noted that conversations among peers about international travel and car ownership made him feel excluded. His experience of commuting by bus and lacking shared cultural references led to social isolation, despite academic success.

These findings align with Bourdieu's concept of institutional habitus, which explains how educational institutions reproduce social hierarchies by privileging certain forms of cultural capital. Students who do not possess these forms of capital, such as polished self-presentation, familiarity with medical jargon, or access to professional networks, are often misrecognised as lacking potential, even when they demonstrate academic excellence.

The emotional toll of misrecognition was evident across participants' narratives and consistently emerged in both interview accounts and survey responses. Feelings commonly described as imposter syndrome, anxiety, and self-doubt were widely reported and were often initially framed by participants as personal shortcomings. Among interview participants, this framing was articulated through extended reflection. For example, Jack, a former foundation-year student, described a persistent sense of not belonging and of having nothing in common with his peers, a feeling that intensified through repeated informal comparisons with those who appeared more socially and economically secure. Similarly, Nicole, a Year 4 participant, reflected on becoming increasingly cautious in how she spoke and presented herself, expressing concern that she was constantly at risk of being exposed as 'not cut out' for medicine.

These emotional experiences were also reflected in survey responses. Josie (Year 2) connected her anxiety and feelings of inadequacy to the pressure of juggling paid work and academic expectations, mentioning that although she understood the course's demands, she 'had no choice' financially. Louise (Year 3) and Stephen (Year 3) also reported feeling

consistently behind or out of sync with their peers, not because of academic ability but due to limited time, exhaustion, and a sense of being unable to fully engage in student life. The repetition of these accounts across both s and s indicates that experiences of self-doubt were not isolated or specific to certain methods but rooted in shared structural conditions influencing students' engagement with medical education.

Importantly, these feelings were not due to personal failings but stemmed from the systemic and cultural barriers ingrained in medical education. As Reay (2017) notes, efforts to increase participation that focus solely on access, without changing institutional structures, risk just reproducing the very inequalities they aim to eliminate, shifting the blame for exclusion onto students. In this study, imposter syndrome was most evident among students in the later stages of training. Interviews with students like Lily (Year 5) and James (Year 4) showed an increase in self-surveillance and doubts about their legitimacy over time, rather than resolving initial uncertainty. Survey results from these later-year students, including Laura (Year 4) and Mo (Year 4), similarly suggested that extended exposure to medical school culture intensified, rather than eased, feelings of not belonging.

Analysed through Burawoy's (2019) articulation of symbolic violence, these accounts show how misrecognition becomes normalised through repeated institutional encounters, leading individuals to internalise structurally produced exclusion as personal failure. The convergence of named survey and interview narratives, therefore, strengthens the analytical claim that, in this study, imposter syndrome functions not as an individual psychological deficit but as a patterned and rational response to ongoing symbolic violence.

Despite these challenges, participants demonstrated remarkable determination. They navigated the admissions process with limited guidance, often relying on chance encounters with supportive teachers or outreach programmes. Joe, for instance, only considered medicine after a doctor visited his school, a rare event that disrupted his internalised assumptions about who could become a doctor. His story, like many others, underscores the importance of relational support and the randomness of opportunity in under-resourced schools.

In summary, while access to medical education has improved numerically, this study's findings reveal that inclusion remains conditional. Working-class students continue to face cultural, emotional, and structural barriers that undermine their sense of belonging. Their presence in medical school is not the end of inequality, but the beginning of a new phase of negotiation, adaptation, and resistance.

Habitus and the Hidden Curriculum

The findings of this study reveal that working-class medical students often experience a profound cultural dissonance upon entering medical school. This dissonance is rooted in a clash between their own habitus, shaped by values of humility, care, and community, and the dominant institutional habitus of medicine, which privileges confidence, detachment, and individualism. Bourdieu's concept of habitus is particularly useful in understanding this tension, as it highlights how students' internalised dispositions, formed through their upbringing and social environment, may not align with the expectations of elite educational institutions.

Participants described how the hidden curriculum, the unspoken norms, values, and behaviours that govern professional identity, reinforced middle-class assumptions about

what it means to be a 'good' medical student. These assumptions were rarely made explicit, yet they shaped everything from how students were expected to speak and dress, to how they interacted with patients and colleagues. For many, this meant learning to perform professionalism in ways that felt inauthentic or even alienating.

Zena, a third-year student, reflected on how her identity became fragmented in the university setting:

'Before I came to uni, I was just Zena. Now I am a female, BAME, working-class medical student' (Zena, year 3).

Her words capture the emotional and psychological impact of being made hyper-visible in an environment that often fails to recognise or value difference. Rather than being seen as an individual, she became a symbol of diversity, expected to represent multiple marginalised identities while navigating a culture that did not reflect her own.

Other participants, like Jack, described the subtle but persistent ways in which they were made to feel out of place. Conversations among peers about gap years, international travel, or family members in the medical profession served as constant reminders of their outsider status. These moments were not overtly exclusionary, but they reinforced a sense of not belonging, what Reay (2017) terms 'institutional dissonance'. These subtle exclusions, though rarely explicit, accumulate over time and contribute to a pervasive sense of emotional strain that students must continually manage. The emotional labour required to manage this dissonance was immense. Students spoke of the need to constantly monitor their behaviour, suppress their accents, or avoid discussing their backgrounds for fear of being judged. This labour was compounded by the pressure to succeed academically and to prove their worth in a system that often failed to acknowledge the additional burdens they carried.

Despite these challenges, many participants resisted assimilation. They drew on their own values and experiences to redefine what it meant to be a doctor. Rather than adopting the emotionally detached model of professionalism promoted by the hidden curriculum, they prioritised empathy, relational care, and cultural humility. These qualities, often dismissed as 'soft skills', were seen by participants as essential to good medical practice, particularly in serving diverse and underserved communities. In this way, working-class students were not only navigating the hidden curriculum, but actively challenging and reshaping it. Their presence in medical education disrupted the reproduction of middle-class norms and opened up space for alternative ways of being and knowing. However, this resistance came at a cost. The emotional and psychological toll of constantly negotiating identity, belonging, and legitimacy was a recurring theme throughout the data.

Ultimately, the findings suggest that the hidden curriculum is not simply a pedagogical issue, but a structural one. It reflects and reinforces broader social inequalities, privileging those whose habitus aligns with institutional expectations while marginalising those who do not. Addressing this requires more than individual resilience, it demands a fundamental rethinking of what is valued in medical education, and a commitment to creating spaces where all students can belong without having to leave parts of themselves behind.

Symbolic Violence and Emotional Labour

The emotional impact of navigating elite environments was a recurring theme in this study. Participants described experiencing accent bias, microaggressions, and class-based assumptions from peers and staff. Within this cohort, all participants were first-generation university students without familial connections to medicine, a positioning that shaped repeated experiences of misrecognition as they navigated institutional norms premised on assumed familiarity and inherited cultural capital. These encounters constitute forms of symbolic violence: subtle yet powerful ways in which institutional norms are reinforced, and inequality is overlooked, leading students to view exclusion as personal failure rather than recognising its structural roots (Burawoy, 2019). The emotional effort required to manage these experiences while still performing academically and maintaining personal identity was significant and often went unnoticed.

Participants described how their working-class backgrounds are often ignored or rendered invisible within the dominant medical education system. Jake, a fourth-year student, recounted that his academic tutor dismissed his financial concerns by jokingly asking if he had a ‘rich uncle’ to support him. While intended as humor, this revealed a significant misunderstanding of Jake’s circumstances and reinforced the notion that financial safety nets are always within reach. Later, when the tutor sent links to budgeting resources, it underscored how institutions tend to individualize economic hardship, framing structural problems as personal mismanagement.

Josie, a second-year student, expressed frustration at being reminded that medicine is a full-time course and that paid work should be minimal. As she explained:

> I do understand, but I have no choice. I do not have enough money.
> *(Josie, Year 2)*

Her account emphasizes the emotional toll of balancing institutional expectations with financial hardship. The idea that students can afford to avoid paid work mirrors a middle-class standard ingrained in medical education, which inherently excludes individuals who need to earn income to survive.

These accounts demonstrate how symbolic violence manifests through misrecognition, where the real experiences of working-class students are not just misunderstood but made to seem illegitimate. The emotional labour involved is not only about managing stress but also about constantly controlling one's identity, suppressing parts of oneself, and projecting confidence in settings that neither reflect nor appreciate one’s background. As Jagger (2025) notes, symbolic violence precisely works through these every day, often unnoticed expectations, requiring individuals to continually modify themselves to seem valid within elite professional environments.

Jack, a former foundation-year student, described how peer conversations about travel, leisure activities, and family connections to medicine accentuated his sense of exclusion. He reflected:

> I feel like I have nothing in common with my peers, and I still live at home with my parents. My leisure time is spent working or studying. I do not have time to fit in with other students.

Such moments of informal exclusion reinforced feelings of not belonging and contributed to the internalisation of inferiority.

Across the cohort, many participants described a persistent sense of self-doubt, feeling they were ‘faking it’ or that their place in medical school was undeserved. Crucially, this was not attributable to a lack of academic ability. Rather, it stemmed from the cumulative effect of being subtly, and at times overtly, reminded that they did not conform to the expected norm. This internalised uncertainty, often labelled as ‘imposter syndrome’, can therefore be understood as a rational response to structural exclusion, produced by culturally embedded forms of symbolic violence rather than an individual deficit (Jagger, 2025).

Despite these challenges, participants demonstrated emotional intelligence and strategic agency. They developed coping strategies, sought supportive peers, and drew strength from their backgrounds. However, these responses should not be romanticised. As Jagger (2025) cautions, institutional narratives that valorise endurance and perseverance risk obscuring the structural conditions that necessitate such emotional labour, shifting responsibility for exclusion from institutions to individuals. Similarly, Reay (2017) warns that framing working-class students as ‘resilient’ can mask inequality and impose additional expectations to perform gratitude in the face of hardship.

The emotional labour described by participants was not confined to the classroom. It extended into clinical placements, where students were expected to perform professional roles that often conflicted with their values and ways of being. For many, this meant suppressing natural communication styles, avoiding discussion of background, and closely monitoring behaviour to pre-empt judgement. This labour was both exhausting and largely unacknowledged within institutional support structures.

In summary, symbolic violence and emotional labour are central to the experiences of working-class medical students in this study. These forms of exclusion are not incidental but are embedded in the culture of medical education. Addressing them requires more than superficial commitments to inclusion. Institutions must recognise the emotional and psychological costs of navigating elite spaces and implement structural change. Only then can medical education create environments in which all students are genuinely valued, supported, and able to thrive without compromising their identities.

Cultural Wealth as Resistance

Mainstream narratives often depict working-class individuals through a deficit lens, suggesting they lack the cultural capital, ambition, or emotional intelligence required to succeed in elite professions. These assumptions are deeply ingrained in institutional practices, media portrayals, and policy discourses, and they continue to shape perceptions of who belongs in the medical field. Within medical education, such narratives manifest subtly, influencing who is seen as a 'natural fit' and who is expected to struggle or assimilate.

However, this study's findings directly challenge these deficit-based assumptions. Working-class medical students did not succeed in spite of their backgrounds but because of the cultural wealth embedded within them. Drawing on Yosso's (2005) framework of community cultural wealth, participants demonstrated how aspirational, familial, navigational, and resistant capital enabled them to persist, adapt, and ultimately thrive in environments that were not designed for them. Aspirational capital was a consistent theme across participants' narratives. Students described a deep-rooted motivation to become doctors, often driven by a desire to serve their communities and improve the quality of care for those who, like their families, had experienced marginalisation within the healthcare system. This form of capital contradicted the stereotype that working-class individuals lack ambition or long-term vision. Instead, their aspirations were grounded in empathy, social justice, and a commitment to relational care.

Intricately linked to this was familial capital. Many students spoke of the emotional and moral support they received from parents, siblings, and extended family members. These relationships provided not only encouragement but also an intense sense of identity and purpose. Meg, a fourth-year student, reflected, 'I am working-class from a council estate, my parents didn't go to uni, but they work hard'. Her pride in her family's work ethic was not just motivational; it was a form of resistance to the deficit narratives that often surround working-class identity. These values of perseverance, loyalty, and care were central to how students understood their role in the medical field.

Navigational capital was evident in the ways students learned to move through unfamiliar and often exclusionary institutional spaces. Participants described having to decode the hidden curriculum, seek out informal mentors, and find creative ways to access opportunities that were not openly advertised. Zena, for example, entered medicine through an access course after caring for her mother and working in adult care. Her journey was marked by determination and resourcefulness, highlighting the strategic agency required to succeed without inherited privilege or insider knowledge.

Most striking was the presence of resistant capital. Students did not simply conform to the dominant culture of medicine, they questioned it. They challenged narrow definitions of professionalism, resisted the pressure to suppress their identities, and brought relational, community-rooted values into their clinical practice. Their lived experiences gave them a unique insight into the social determinants of health and a deep understanding of the importance of listening to patients as whole people. This resistance was not always loud or confrontational. Often, it took the form of quiet persistence, of holding onto one's values in the face of pressure to conform. Building on Jagger's (2025) analysis of symbolic violence and symbolic resistance within elite professions, these practices can be understood not merely as coping strategies but as forms of symbolic resistance through which working-class students contest misrecognition and assert the legitimacy of their values, identities, and ways of caring within medical education.

Chantal, a second-year student, exemplified this quiet resistance. She explained,

> Whilst my education and career choice may be seen as middle-class, my experiences of attending a university as a first-generation, scholarship student and social interactions are wholly working-class.

Chantal's refusal to abandon her identity was not a limitation; it was a powerful act of cultural defiance. In maintaining her authenticity, she disrupted the assumption that success requires cultural erasure.

In addition to these established forms of capital, many participants demonstrated what recent scholarship refers to as perspective capital, a critical awareness of inequality developed through lived experience. Students showed a heightened ability to reflect on the structures around them, not only in education but in healthcare more broadly. This awareness enabled them to question institutional norms and advocate for more inclusive, compassionate approaches to care. Their insights were not only personally transformative but had the potential to reshape the profession itself.

Taken together, these findings contradict dominant narratives that frame working-class identity as something to be escaped or corrected. Instead, they reveal that working-class students bring essential values, perspectives, and skills into medicine—qualities that are often overlooked but urgently needed. Their presence is not a problem to be managed, but a resource to be recognised and celebrated.

In conclusion, working-class medical students are not only navigating exclusionary systems but are also actively reshaping them. By utilising community cultural wealth, they resist deficit narratives, redefine professionalism, and bring relational, community-based values into the core of clinical practice. Their stories remind us that inclusion is not about making students conform to existing norms but about transforming institutions to recognise and value the full spectrum of human experience. Their resistance is not merely a personal act of survival, but a collective call for a more just and compassionate medical profession.

Precarity and the Myth of Stability

For many working-class students in this study, the decision to pursue medicine was based on a desire for long-term security, stability, and social mobility. Medicine was seen not only as a prestigious profession but also as a reliable route out of economic insecurity, a career that offered financial independence, job stability, and a respected status in society. However, the findings of this research show a growing disconnect between the symbolic prestige of medicine and its real-world realities. The promise of stability, once a core attraction of the profession, is increasingly challenged by systemic changes in the healthcare sector and the lived experiences of students and early-career doctors.

Participants entered medical school with the belief that their hard work would be rewarded with a secure and fulfilling career. Yet, as they progressed through their training, many began to question this assumption. They encountered a profession marked by long hours, emotional exhaustion, and growing uncertainty about future employment. The erosion of pay, the intensification of workloads, and the deprofessionalisation of junior doctors were all cited as sources of disillusionment. These realities were particularly stark for students who lacked financial safety nets or familial support, and who had invested heavily, emotionally, financially, and socially, in the pursuit of medicine.

Chantal, a second-year student, reflected on this tension:

> I thought medicine was a good career choice with a guaranteed job at the end of the training. I know many people who have degrees but have not managed to find a

> graduate job, and for me, if I had not managed to get into medicine, I would not have taken the risk of attending university.

Her words highlight the calculated nature of educational decisions for working-class students, who often cannot afford to take risks without a clear return. When the reality of the profession fails to meet these expectations, the emotional and psychological impact can be profound.

This sense of precarity was not limited to future employment. It was also felt during training, particularly in the form of financial strain, housing insecurity, and the pressure to work part-time jobs alongside demanding academic schedules. Josie, for example, described the impossibility of meeting basic living costs without paid work, despite institutional expectations that students should focus solely on their studies. These pressures were compounded by the rotational nature of medical training, which often required students to relocate frequently, disrupting support networks and increasing financial instability.

The findings also reveal a broader shift in how medicine is experienced by those entering the profession. While the public image of the doctor remains one of authority and respect, the day-to-day reality is increasingly characterised by managerial oversight, reduced autonomy, and emotional burnout. For working-class students, who often enter medicine with a strong ethic of care and a desire to make a difference, this disconnect can be particularly disheartening. The profession they imagined, one rooted in service, stability, and respect, is not always the one they find.

This contradiction between expectation and reality reflects what Bourdieu (1991:8) describes as symbolic violence: the internalisation of institutional norms that obscure structural inequalities. Students are encouraged to believe that success is a matter of effort and merit, yet the system they enter is shaped by forces beyond their control. When the rewards of the profession fail to materialise, the burden of disappointment is often borne individually, rather than recognised as a systemic issue. Taken together, the findings show how misrecognition functions as the mechanism through which symbolic violence is reproduced in medical education, while everyday practices of pride, relational care, and refusal to assimilate operate as forms of symbolic resistance that challenge elite professional norms (Burawoy, 2019; Jagger, 2025).

Moreover, the myth of stability in medicine serves to mask the growing inequalities within the profession itself. Students from more privileged backgrounds may be better equipped to navigate the uncertainties of training and employment, drawing on financial support, professional networks, and cultural familiarity. In contrast, working-class students are more vulnerable to the consequences of instability and less able to absorb the costs of delayed progression, relocation, or underemployment.

In conclusion, the findings of this study challenge the enduring narrative of medicine as a stable and secure profession. For working-class students, pursuing a career in medicine is often a high-stakes investment, made in the hope of achieving long-term security. Yet, the realities of the profession increasingly reflect a landscape of precarity, emotional strain, and structural inequality. Recognising this disconnect is essential, not only for supporting students more effectively, but for rethinking the values and structures of the profession itself. If medicine is to remain a meaningful and accessible career for all, it must confront the myth of stability and address the conditions that undermine it. Taken together, the findings show

how misrecognition functions as the mechanism through which symbolic violence is reproduced in medical education, while everyday practices of pride, relational care, and refusal to assimilate operate as forms of symbolic resistance that challenge elite professional norms (Burawoy, 2019; Jagger, 2025).

Conclusion and Recommendations

This thesis aimed to explore how working-class medical students experience entering an elite profession and what their stories reveal about the cultural, structural, and emotional aspects of inequality in medical education. Although initiatives to broaden participation have improved access to medical schools, the results of this thesis demonstrate that admission is merely the starting point of a more extensive process of negotiation, adaptation, and emotional effort. For these students, class identity did not disappear after entering medical school; instead, it became more apparent in the daily practices, expectations, and norms that define medical training.

The initial chapter examined how early educational backgrounds, and the hidden curriculum of medical admissions influence students' paths well beyond their entry to university. Many participants stated they were academically ready but felt culturally out of place, noting that their peers often had social and cultural capital, knew medical jargon, felt confident in academic environments, and received informal guidance from family resources they lacked. These early inequalities persisted after admission, subtly impacting confidence, engagement, and access to opportunities. The chapter highlighted that policies aimed at widening participation based solely on access may overlook the lasting effects of unequal preparation.

The second discussion chapter examined how class shaped belonging and identity within the university and at home. Students described a constant awareness of difference, expressed through accent modification, self-censorship, and careful management of how much of their home lives they revealed. These practices were not signs of insecurity but rational responses to environments in which middle-class norms were treated as neutral. Yet home remained a powerful source of grounding, pride, and emotional support. Rather than distancing themselves from their origins, participants maintained strong ties to family and community, even when this required significant emotional labour. The chapter demonstrated that belonging is not simply a matter of 'fitting in' but a relational, classed process shaped by institutional culture and personal history.

The third chapter of the discussion explored how class-based dynamics became more pronounced within clinical environments. In this context, professionalism was subtly linked to middle-class traits such as confidence, familiarity with hierarchical structures, and emotional detachment. Conversely, working-class students often demonstrated relational and structural skills rooted in their personal experiences, including an understanding of poverty, limited choices, and distrust of institutions. However, these valuable insights rarely gained recognition as legitimate expertise. Instead, students felt their relational care approaches were often undervalued or dismissed as overly emotional. This chapter highlighted a significant disconnect between the practical knowledge working-class students possess and the types of capital valued by medical training.

Taken together, the findings reveal a consistent pattern: medical schools increasingly recruit working-class students, but the institutional cultures they enter remain shaped by middle-class norms. Students described exhaustion, identity conflict, and persistent feelings of being out of place, even when academically successful. Inequality in medical education is therefore not only material or academic but deeply cultural and emotional. Class operates through subtle mechanisms, accent scrutiny, assumptions about professionalism, hidden rules of progression, and the undervaluing of relational knowledge, all of which cumulatively shape students' experiences and opportunities.

Yet this thesis also challenges deficit narratives. Across all chapters, participants demonstrated resilience, insight, and commitment. Their motivations were often grounded in relational ethics, a desire to give back, to honour family sacrifices, or to improve care for communities like their own. Their lived experiences provided them with a nuanced understanding of the social determinants of health, enabling them to practise medicine in ways that were empathetic, culturally attuned, and socially aware. These findings suggest that working-class students do not simply adapt to medicine; they expand its possibilities.

Policy and Practice Implications

The findings of this thesis point to several areas where medical schools and policymakers must act if widening participation is to move beyond symbolic inclusion.

1. Belonging should be prioritised structurally. According to students, belonging is influenced more by institutional culture than by individual resilience. Medical schools need to track belonging, well-being, and access to opportunities throughout the degree program, recognising that exclusion often occurs in informal settings, such as study groups, clinical teams, and social events, rather than in formal teaching.
2. Staff require training in class-conscious pedagogy and pastoral care. Participants consistently reported encounters where tutors misunderstood or downplayed experiences related to class, like commuting, caregiving, or financial difficulties. Support is most impactful when it is relational and based on recognition. Medical schools should incorporate class awareness into staff development programs, covering topics such as symbolic violence, misrecognition, and the emotional labour involved in social mobility.
3. Accent bias must be explicitly addressed. Students described linguistic scrutiny as a key mechanism of misrecognition. Medical schools should incorporate accent bias into Equality, Diversity and Inclusion and professionalism training, and challenge assumptions that middle-class speech patterns represent neutrality or competence..
4. Financial precarity must be reduced. Long commutes, part-time work, and hidden costs limited students' participation in informal learning and enrichment opportunities. Medical schools should expand bursaries, subsidise placement and living costs, diversify elective options, and provide paid opportunities for widening participation students.
5. Community matters. Students found a sense of belonging through connections with others from similar backgrounds. Medical schools should support working-class peer networks, mentoring schemes with clinicians from similar backgrounds, and safe spaces where classed experiences can be discussed without stigma.a.

6. Lived experience should be recognised as a form of professional knowledge. Participants' relational and structural competence enriched their clinical practice, yet this was rarely acknowledged. Medical schools should embed structural competence in the curriculum and involve working-class students in curriculum design.
7. Admissions, assessment, and early-career pathways must be demystified. Participants described these processes as opaque and governed by hidden rules. Medical schools should provide transparent guidance on interviews, portfolio development, research opportunities, and networking.

Areas for Further Research

This thesis opens several avenues for future inquiry:

- How class intersects with race, gender, disability, and migration status in medical education.
- How working-class doctors navigate postgraduate training, speciality choice, and professional hierarchies.
- Evaluating class-aware pastoral support, accent bias training, and structural competence curricula.
- How lived experience shapes patient care, communication, and decision-making in real clinical settings.
- Ethnographic studies of clinical teams to examine how professionalism is enacted and policed.

Such research would deepen understanding of how class operates across the medical profession and inform more equitable institutional practices.

Contribution to Knowledge

This thesis makes a distinctive contribution to understanding how class shapes the experiences of medical students and the cultures of medical education. Empirically, it offers one of the first in-depth qualitative accounts that follows working-class students throughout the full trajectory of medical training. By tracing their journeys from early educational experiences through university and into clinical placements, the study reveals how class continues to shape belonging, identity, and access to opportunity at every stage. Rather than treating widening participation as an admissions issue, the thesis demonstrates that classed inequalities persist in subtle, cumulative ways long after students enter medical school.

The study also advances theoretical debates by extending the Bourdieusian and Community Cultural Wealth frameworks into the clinical domain. It shows that professionalism is not a neutral set of behaviours but a classed construct that privileges middle-class dispositions, such as confidence, ease with hierarchy, and emotional detachment. At the same time, the study highlights how working-class students draw on relational and structural competence grounded in lived experience. These insights enrich patient care yet remain undervalued within existing professional norms. In doing so, the thesis demonstrates the analytical value of bringing Bourdieu and Yosso into conversation within medical education.

The thesis introduces the concept of structural belonging to explain the cultural, emotional, and institutional factors that shape students' experiences. It shifts the focus of widening participation from an individual effort to a collective and institutional obligation. This approach emphasises the need to change the norms, expectations, and hidden rules that guide medical education, rather than expecting students to conform to environments not built with their needs in mind.

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Appendix 1 – Participant demographic table

	Participant pseudonym	Year of Study	Age range	Gender	Commuter Student	Family Carer	Ethnicity	Interview/ Survey
1	Chantal	Year 2	21-25	Female	Yes	Yes	Mixed Caribbean/British	Interview
2	Nicole	Year 4	21-25	Female	Yes	No	White/British	Interview
3	Josie	Year 2	21-25	Female	No	No	White/British	Survey
4	Meg	Year 4	21-25	Female	Yes	Yes	White/British	Interview

5	Joe	Year 3	26-30	Male	Yes	Yes	White/British	Interview
6	Lucy	Year 2	21-25	Female	No	No	White/British	Interview
7	Sophie	Year 3	21-25	Female	No	No		Interview
8	Zena	Year 3	26-30	Female	No	Yes	Pakistani/British	Interview
9	Leon	Year 3	36-40	Male	No	Yes	White/British	Interview
10	Jack	Year 1	21-25	Male	Yes	No	White/British	Survey
11	Pete	Year 2	21-25	Male	Yes	No	White/British	Interview
12	Louise	Year 3	21-25	Female	Yes	No	White/British	Survey
13	Ted	Year 2	21-25	Male	No	No	White/British	Survey
14	Joanna	Year 3	21-25	Female	No	No	White British	Survey
15	Natasha	Year 3	21-25	Female	No	No	White British	Interview
16	Alex	Year 4	21-25	Female	No	No	White/British	Interview
17	Josh	Year 2	21-25	Male	No	No	Black/Carribean	Interview
18	Lily	Year 5	26-30	Female	Yes	No	White/British	Interview
19	Laura	Year 4	21-25	Female	No	Yes	White/British	Survey
20	Stephen	Year 3	31-35	Male	Yes	No	White/British	Survey
21	James	Year 4	26-30	Male	Yes	No	Black/British	Interview
22	Rosie	Year 2	21-25	Female	No	No	White/Britsih	Interview
23	Amina	Year 2	21-25	Female	Yes	No	Asian/British	Interview
24	Callum	Year 5	21-25	Male	No	No	White/British	Interview
25	Chloe	Year 4		Female	No	No	White/British	Interview
26	Mo	Year 4	21-25	Male	Yes	No	Asian/British	Survey
27	Zoe	Year 2	21-25	Female	Yes	No	White/British	Survey
28	Shabina	Year 4	21-25	Female	Yes	Yes	Pakistani/British	Survey
29	Kitty	Year 3	26-30	Female	No	Yes	White/British	Survey
30	Tiffany	Year 5	21-25	Female	Yes	No	White/British	Interview
31	Harvey	Year 2	21-25	Male	No	No	White/British	Survey

32	Sid	Year 3	31-25	Male	Yes	Yes	Asian/British	Survey
33	Jess	Year 3	21-25	Female	No	No	White/British	Interview
34	Tom	Year 4	21-25	Male	No	No	White/Irish	Survey

Appendix 2 – Interview Schedule

Pre-Interview questions.

- Age
- Gender identity: _____
- Racial/ethnic background (self describe): _____

Social Class Identity

- How would you describe your social class?

☐ Working class

☐ Middle class

☐ Upper middle class

☐ Other (please specify): _____

Commitments Beyond Medical Training

- Employment outside studies:

☐ No work commitments

☐ Work under 12 hours per week

☐ Work more than 12 hours per week

- Caring responsibilities:

☐ None

☐ Parenting responsibilities

• Number of children: _____

• Ages of children: _____

• Any children considered disabled? ☐ Yes ☐ No

☐ Caring for a family member

• Relationship to you: _____

Accommodation

- Current accommodation:

☐ University owned accommodation

☐ Private student accommodation

☐ Living with parents / commuting student

☐ Private rented accommodation

☐ Social housing tenant

☐ Owner occupier

Family Educational Background

- Did either of your parents attend university? ☐ Yes ☐ No
- Did any siblings attend university before you began studying? ☐ Yes ☐ No
- If applicable, have any of your children attended university? ☐ Yes ☐ No

Social Connections

- Prior to medical school, did you have any close family members or friends who were doctors?

☐ Yes ☐ No

Secondary Education

- Type of school attended prior to university:

☐ Private school (Day / Boarding)

☐ Selective grammar school

☐ Secondary academy

☐ State-maintained secondary school

Interview Questions

The interviews were conducted using a semi-structured format. Questions served as prompts and were adapted to encourage narrative depth and reflexive discussion.

Section 1: Early Aspirations and Educational Trajectory

1. At what age did you first consider applying to medical school?

2. Can you tell me about what first motivated you to pursue medicine?

3. Were there any individuals or experiences that influenced this decision (e.g. teachers, family members, role models)?

4. In what ways, if any, has your motivation changed during your training so far?

Section 2: Access, Admissions, and Transition

5. Why did you choose your current university?

6. When you were considering medical school, what advice or support did you receive, and from whom?

7. Thinking back to enrolling on your course, how prepared did you feel for starting medical school?

8. What forms of support, if any, did your university provide before or during your first year?

Section 3: Belonging, Relationships, and the Hidden Curriculum

9. How informed have you felt about academic expectations during medical school?

10. How informed have you felt about opportunities to network and build professional connections?

11. To what extent have you developed relationships with other medical students?

12. Have you formed relationships with students from other disciplines within the university?

13. To what extent have you developed relationships with academic or clinical staff?

14. Can you describe a relationship that has felt particularly meaningful or important during your training?

Section 4: Comfort, Confidence, and Emotional Experience

15. During your training, in what settings have you felt most comfortable or confident?

16. What aspects of medical training have you found most challenging or worrying?

17. What experiences have made you feel proud or affirmed during your training?

Section 5: Professional Identity and Clinical Practice

18. How do you feel your training has prepared you to build relationships with patients?

19. How confident do you feel in tasks such as taking a patient history or developing a treatment plan?

20. Have you ever felt uncomfortable raising concerns in clinical settings? Please explain if you feel able.

Section 6: Class, Background, and Relationships

21. In what ways, if any, do you think your background has influenced your relationships with peers or colleagues?

22. How do you think your life experiences shape your relationships with patients?

23. Drawing on your clinical experiences, do you feel all patients are equally heard and involved in decisions about their care?

24. To what extent have you been able to maintain relationships with family members and friends from home since starting medical school?

25. In what ways, if any, have these relationships changed during your training?

26. Have you ever felt tension between home and university worlds? Please explain if relevant.

Section 7: Reflection

27. Looking back, to what extent have your expectations of medical training been met?

28. Is there anything else you feel is important to share about your experience of becoming a doctor?