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Travels in extreme social mobility: how first-in-family students find their way into and through medical education

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\textbf{ABSTRACT}

Higher education is understood as essential to enabling social mobility. Research and policy have centred on access to university, but recently attention has turned to the journey of social mobility itself – and its costs. Long-distance or ‘extreme’ social mobility journeys particularly require analysis. This paper examines journeys of first-in-family university students in the especially high-status degree of medicine, through interviews with 21 students at an Australian medical school. Three themes are discussed: (1) the roots of participants’ social mobility journeys; (2) how sociocultural difference is experienced and negotiated within medical school; and (3) how participants think about their professional identities and futures. Students described getting to medical school ‘the hard way’, and emphasised the different backgrounds and attitudes of themselves and their wealthier peers. Many felt like ‘imposters’, using self-deprecating language to highlight their lack of ‘fit’ in the privileged world of medicine. However, such language also reflected resistance to middle-class norms and served to create solidarity with community of origin, and, importantly, patients. Rather than narratives of loss, students’ stories reflect a tactical refinement of self and incorporation of certain middle-class attributes, alongside an appreciation of the worth their ‘difference’ brings to their new destination, the medical profession.

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\textbf{Introduction}

(Un)iversities don’t control the drivers of earnings inequality such as the tax transfer system and the minimum wage level. Nor do we control global capitalism, the knowledge economy and the demand for ever-increasing skill levels … What we can do, however, is help distribute more evenly the spoils of higher education and disrupt the patterns of inherited advantage, which increasingly divide society (Parker, 2016, np).
The massification of Western higher education has led to an increase in students from non-traditional backgrounds attending university (Altbach, 2013). The term non-traditional student describes people who have historically been under-represented in universities and includes: people from low socio-economic status (LSES) and first-in-family (FiF) backgrounds; people from particular cultural and ethnic groups; the mature aged; those from rural and remote areas; and people with a disability (Schuette & Slowey, 2002). Despite the successes of widening participation policy, non-traditional students remain vastly under-represented in elite institutions (Reay, Crozier, & Clayton, 2009) and in high-status professional degrees such as law, engineering, architecture, and particularly medicine (Cleland, Dowell, McLachlan, Nicholson, & Petterson, 2012). Internationally, non-traditional students’ lack of access to high-status degrees remains an enduring equity problem (Granfield, 1991; Kirby, 2016). Gale (2012) states that for ‘equity to have real teeth, proportional representation … needs to apply across institutions and course types’ (p. 246). This resonates with Parker’s (2016) argument on redistributing the benefits of higher education to counter the inequitable effects of inherited advantage.

Knowledge of how to fairly distribute the ‘spoils of higher education’ would be expanded by developing an understanding of the journeys of ‘long-range’ or extreme social mobility undertaken by non-traditional students enrolled in high-status degrees (Laurison & Friedman, 2015). Journeys of extreme social mobility involve travelling long social distances, from self-professed ‘humble’ family origins into the world of higher education, progressing through the most elite degrees, and finally, into membership of the professions. There is much to learn from travellers in extreme social mobility, including perspectives on how their backgrounds influence the direction of their journey, how they manage to access and succeed in the degree, and the effects of the journey on personal and professional identity formation. Despite the value of such insights, relatively little is known about the experiences of non-traditional students who do succeed in gaining access to high-status degrees and their associated professions (Granfield, 1991).

This article reports on qualitative research with FiF medical students in an Australian medical school. The study was guided by the research question: What are the experiences of FiF medical students in medical education and how do they understand their personal and professional journey through a high-status professional degree? In this paper, we begin by critically examining the concept of social mobility and reviewing the literature on FiF and LSES students in medical education. We then present an overview of the study followed by an analysis of the social mobility stories of FiF medical students, with a focus on: their family and community background, schooling and aspiration to medicine; experiences of being different in medical education; and professional identity formation and ambitions.

**Literature review**

**Critical perspectives on social mobility and elite professions**

Social mobility is a change in the social status of individuals or groups as a result of moving from social origin to a new social destination, usually through occupational
change, both within and between generations (Payne, 1989). Patterns of social mobility are linked to economic inequality as family background plays a bigger role in determining adult outcomes than individual characteristics such as ability, talent, and effort (Mendolia and Siminski, 2015, p. 4). Many governments and transnational organisations have focused on measuring rates of social mobility (Causa & Johansson, 2010; Milburn, 2012) and these vary between countries. For example, Australia and Canada have higher rates of social mobility than the UK and the US (Causa & Johansson, 2010).

Laurison and Friedman (2015) observe that while sociology has a history of investigating the effects of social mobility, this line of enquiry has been largely abandoned in favour of measuring generalised rates of mobility. While this observation is generally accurate, there is a literature on the transition of working-class and ethnic minority students into elite universities which highlights experiences of ambivalence, disorientation, and marginalisation (Reay et al., 2009, 2010; Tett, 2004).

Other studies have documented the disadvantage that people from working-class and ethnic minority backgrounds face in high-status professions (Ashley & Empson, 2013; McDonald, 2014). One study on non-educational barriers to entry into elite legal and financial services firms, found that there is a strong tendency for these companies to recruit new entrants from a narrow range of elite universities and that the companies define ‘talent’ according to factors such as confidence and ‘polish’ which can be mapped on to a middle-class form of socialisation (Ashley, Duberley, Sommerlad, & Scholarios, 2015, p. 6).

Social mobility is often conceptualised as a ‘problem’ of access into occupations rather than a journey into and within the professions. Laurison and Friedman (2015) found that in professions such as medicine and law there were distinct patterns of ‘micro-class reproduction’: children with parents in these occupations were, respectively, 21.6 and 18.9 times more common in the profession than the population as a whole. Moreover, there was a substantial earnings difference amongst those in the elite occupations such as medicine with the upwardly mobile earning far less per week than those who were from the same elite occupational group as their parents. The authors recommend research on how the class-based, embodied dispositions, or habitus (Bourdieu, 1977) of upwardly mobile individuals are implicated in such inequality.

Friedman (2014) suggests that the scholarly and policy fixation on measuring rates of mobility has ‘acted to inadvertently reify the notion that mobility is an entirely progressive force’ (p. 2). He posits that there is a need to go beyond ‘celebratory discourses’ to offer more nuanced accounts of the ‘price of the ticket’ of social mobility. Medical education, a vehicle to a profession of the highest status, provides an ideal setting to explore the benefits and costs of social mobility.

**FiF and LSES students in medical education**

Widening participation research indicates a strong association between LSES and FiF status (for example, Stephens, Fryberg, Markus, Johnson, & Covarrubias, 2012). The literature on social diversity in medical education uses either LSES and/or FiF, hence the foci of this literature review. Medical school admissions data from Australia (Department of Education, 2014), the UK (Cleland et al., 2012), the US (Fenton et al., 2016), and Canada (Association of Faculties of Medicine of Canada, 2012)
indicate a disproportionately low intake of non-traditional students, with minimal improvement over time. Indeed, despite considerable investment in widening participation initiatives, the proportion of students from LSES backgrounds in UK medical schools has declined from 14% to 11% (Cleland et al., 2012). In Australian medical schools 16% of students are from LSES backgrounds, with 46% from middle SES, and 38% from high SES backgrounds (Department of Education, 2014). There has also been an effort amongst some Australian medical schools to increase the number of Indigenous doctors by developing preparation programmes, adjusting selection processes, and implementing academic and social support mechanisms (Lawson, Armstrong and Van Der Weyden, 2007).

The case for increasing diversity in medicine dates back several decades (Fox, 1979). Medical educators have argued that to provide the best possible care, doctors should mirror the diversity of the communities in which they work (Garlick & Brown, 2008), with some proposing that medical students from minority groups are more likely to work in underserved areas (Jones, Humpreys and Prideaux, 2009). Peak medical associations argue that medical schools must ensure that applicants are suited to the profession, regardless of sociocultural background (British Medical Association, 2009). Most research has focussed on improving fair access to medical school through application and admission processes (Sullivan & Mittman, 2010) and interventions such as foundation pathways, pipeline and summer school programmes, and school outreach (Greenhalgh et al., 2006).

Qualitative studies have identified barriers to medical school access finding that LSES high school students: lacked a sophisticated knowledge of the medical ‘admission game’ (Robb, Dunkley, Boynton, & Greenhalgh, 2007; Wright, 2015); believed that medical education was only for ‘posh’ people (Robb et al., 2007); underestimated their chances of admission to and success in the degree (Greenhalgh, Seyan, & Boynton, 2004); and had few opportunities to undertake ‘taster’ work experience in the health industry (Southgate, Kelly, & Symonds, 2015).

A UK study of working-class, mature-age medical students found that the course was not as difficult as these students initially thought and that the student body was more diverse than expected prior to admission (Mathers & Parry, 2009). A Canadian study indicated that some working-class students had problems fitting into the culture of medical school because they did not have the same tastes and hobbies as their wealthier peers and Faculty who sometimes made dismissive comments about poor people (Beagan, 2005). A Bourdieuian analysis of the study reported in this article, found that Australian FiF students identified the absence of health professionals within their networks as a significant barrier in applying to medical school and during their medical education (Brosnan et al., 2016). This limited literature provides some insight into the tensions faced by non-traditional students studying medicine, indicating a need for closer examination of their travels in extreme social mobility.

The study

The data presented here are drawn from a study that explored experiences of, and barriers and enablers to, medical education for FiF students. The term FiF, defined as students whose parents had not been to university, was used to recruit students as it was...
less stigmatising than LSES. FiF provided an ‘umbrella’ category for non-traditional students from LSES, Indigenous, and rural backgrounds (such social differences do intersect). All undergraduate medical students received an email from their year coordinator inviting them to participate in the research if they identified as FiF. Twenty-one domestic students volunteered for a 1 hour, semi-structured interview focusing on: family and community background; motivation and pathway to medicine; experiences of medical education; barriers and enablers to medical education; and future aspirations. Participants completed a brief demographic questionnaire to determine their SES and cultural backgrounds. A $30 supermarket voucher was given as token of appreciation after the interview. The study received institutional ethics approval.

The sample reflected the characteristics of non-traditional students including an overall LSES profile. The majority (14/21) lived in postcodes that fell within the bottom 50% of areas in the Index of Relative Socioeconomic Disadvantage (Australian Bureau of Statistics, 2013). The highest parent occupational prestige scores averaged 53/100 on the Australian Socioeconomic Index 2006 (McMillan, Beavis, & Jones, 2009), a score on a scale ranging from 0 (lowest occupational prestige) to 100 (highest occupational prestige). On this index, medical practitioners are the only occupational group to score 100. Participants described their background as ‘just working class people’ comprising ‘tradies’ (tradespeople), farmers, labourers, miners, cleaners, secretaries, ‘stay-at-home mums’, small business people, care assistants, and nurses with a vocational credential. Nine participants were aged in their late teens to early 20s, with 12 participants aged in their mid-20s to mid-30s. Australian statistics for 2014–2015 indicate there is gender parity in medical education with 2% of commencing students from Indigenous backgrounds (Medical Deans Australia and New Zealand, 2015). Sixteen participants in our study were female and five male. Seven identified as Indigenous. The high representation of Indigenous students in our sample reflects a confluence of Indigenous background with FiF status. Fourteen participants came from a rural or regional area as determined by the Australian Standard Geographical Classification system (Australian Bureau of Statistics, 2006). Fifteen were in their first or second years of medical school with the remaining in years three to five of undergraduate study. FiF medical students are a small minority within Australian medical schools. This paper presents some very sensitive personal stories. Thus, although we have anonymised the setting, to further maintain the anonymity of participants we have chosen to assign only two demographic descriptors (gender and Indigenous/non-Indigenous cultural status) to interview extracts.

Interviews were recorded, transcribed, and analysed with a coding framework developed both inductively and deductively (Creswell, 2013). Interpretation of data was guided by a thematic network analysis approach (Attride-Stirling, 2001) in which data were coded for basic, organising, and global themes. Inductive coding involved mapping and synthesising emerging themes, issues and phenomena. Deductive coding drew on a range of social theory that ‘resonated’ with the emerging findings from the inductive coding process (these social theories are discussed in the next section). For this paper, coding was undertaken by the first author with co-authors providing feedback on the credibility of the interpretation (Creswell & Miller, 2000).
Theoretical approach

Our approach in this article is informed by a critical interpretive epistemological framework that seeks to bring forth the standpoints of various groups, particularly disadvantaged people (Creswell, 2013). During the analytic process certain social theories were identified as providing valuable explanatory lenses for the phenomena that were emerging. We therefore adopted a position of theoretical eclecticism as a means of authentically and cautiously representing and interpreting these phenomena. This aligns with Sil and Katzenstein’s (2010, p. 412) position on eclecticism as a middle-range theoretical stance that pragmatically seeks to address the complexity and messiness of experience and its implications for practice. Hence, in this article we deploy a number the conceptual tools and insights from theorists interested in disadvantage, marginalisation and social justice, and weave these through as they resonate with the analysis. Influential to our analysis are Goffman’s (1963) work on stigma, specifically the notion of ‘discredited’ and ‘discreditable’ identities and the Bourdieuan-inflected research of Reay, Crozier, and Clayton (2009, 2010) on the dispositions and psychic economy of non-traditional university students. We also found Fraser’s (1998) concept of recognitive social justice to be useful. Fraser (1998) describes the politics of social recognition as manifesting in a ‘difference-friendly world, where assimilation to majority or dominant cultural norms is no longer the price of equal respect’ (p. 1). This concept provides a potentially positive way of reframing ‘deficit’ perspectives in education, and of provoking question about what respectful practice in education might look like.

Finally, while we were attuned to using intersectionality (Crenshaw, 1989; Southgate et al., 2015) to account for the interplay between gender, culture, social class, and geographic background, the participants’ narratives reflected powerful commonalities of experience rather than difference. There are probably two reasons for this. Firstly, the methodological approach yielded a modest data set comprising of mainly one-off, 1 hour interviews, constraining opportunities to explore nuanced intersections of social difference with participants. A larger study based on a more specific purposive sampling frame (Creswell, 2013) constructed around social characteristics might draw out intersections and interplays of difference more strongly. Secondly, FiF medical students are also generally from LSES backgrounds and are a very small minority in a degree primarily populated by students from upper-middle class and even very wealthy backgrounds. This minority status within such an elite context appeared to have had the effect of highlighting a very stark sense of their difference based on ‘humble’ family backgrounds. Humbleness was related to hardship in childhood and adulthood, a state school education, and an anti-pretentious attitude. This said we have included narratives from Indigenous participants that refer to the value of culture and ‘mob’ (cultural and kinship relationships), and experiences of racism. We do acknowledge that there is further work to be done on intersections of difference in this field.

Findings

Three major themes on the social mobility journey of participants are discussed. The first focuses on the starting point of participants’ social mobility journey and includes
reflections on family background, schooling, and aspiration to medical school. The second concentrates on medical education, with a focus on how sociocultural difference is understood, experienced, and negotiated. The third theme explores how participants think about their professional identity formation and their future in medicine.

‘Life isn’t that simple and lovely’: family background, schooling, and aspiration to medicine

For most participants the pathway towards medical school was circuitous and, in some cases, protracted. Only two had taken a direct route from high school, propelled by a clear goal to study medicine. Five participants had taken a ‘gap’ year or two in which they decided what they would like to do post-school. Five (mostly Indigenous) students had come from university enabling programmes undertaken either as mature aged students or as an alternative to the higher school certificate. Other participants had either completed or partially completed a degree and/or were in the workforce when they decided to apply to medical school. Generally, to quote one female participant, their life trajectories were neither ‘simple’ in terms of portraying a linear ‘normal’ biography (Kohli, 2007, p. 258) nor ‘lovely’, in the sense of being relatively carefree and uncomplicated. An Indigenous student summed up the complex routes to medical education as ‘getting there the hard way’.

Many recalled happy childhoods, with some explaining the ‘sacrifices’ and ‘struggles’ that their parents made in support of their children’s education. One Indigenous student summed up a feeling amongst the group when she stated that she did not want to complain because, although there was ‘not a whole lot of privilege in (her) life, (she felt she) was not particularly hard done by’. There were some narratives that depicted fairly dire family circumstances, with one non-Indigenous female participant remarking that her childhood was ‘just bad memories (of) living in the ghetto’. Another non-Indigenous female participant recounted a childhood disrupted by her mother’s addiction; however, this struggle was framed in terms of family solidarity:

‘I didn’t know dad. My mum didn’t do anything. Mum was a drug addict and an alcoholic most of my life. She went to rehab when I was in Year 12 and she’s been good since. My grandmother was around and she did anything and everything … Mum was always there, but in the house I was more of the adult when I was home and Nan would kind of support us’.

Some non-Indigenous participants jokingly used the term ‘bogan’ to describe the community they grew up in, and in many cases, where their families still resided. Bogan is used as a derogatory descriptor for those from a white Australian working class milieu, similar to British ‘chav’ or American ‘trailer trash’ (Adams & Raisborough, 2011). One female participant said she was from ‘Bogan City’, while a male student called himself ‘99% medical student, 1% bogan’. As Gibson (2013) suggests, the humorous self-referential use of the term ‘bogan’ acts to legitimise Australian working-class identity.

The act of humorously legitimating one’s social class background did not necessarily extend to experiences of schooling. A couple of participants had gone to private schools (as a result of their family’s ‘sacrifices’) and one had attended an academically selective public school. The schooling experiences of these participants were mainly positive with
them describing ‘great teachers’, good career advice, and a supportive group of friends. Others viewed their schooling as far from satisfactory. An Indigenous woman described her school as ‘dero’ (derelict), while another said her school had ‘a bit of a bad reputation’. For many, career guidance was particularly unhelpful:

‘(C)ertainly at school there was no inspirational speakers. I think there was a career counsellor … they just wanted to keep the kids – they were pretty naughty at that school so it was all about trying to put out fires rather than get the good kids to reach their potential’ (non-Indigenous female).

‘I went to a career advisor and she told me – because I was from (an area) which has a lot of mining activity around it – She said, "You should do some engineering … You’re good at maths." So that’s what I did. Then I started engineering. I did it for about three or four weeks and I realised very quickly that it wasn’t for me’ (non-Indigenous male).

A few participants were discouraged from going to university. One female student stated: ‘I had teachers telling me I was going to fail and stuff when I never really had any problems academically.’ An Indigenous female participant recounted a story of racism:

‘I wanted to do it (medicine) as a kid but I was told at high school that it was never going to be possible so I went to (post-school vocational education) … My high school principal told me I was going to be a typical Aboriginal drop out with lots of babies … I would have been 15 or 14 at the time’.

Timely access to specialist knowledge about university and medical education is imperative for non-traditional students (Greenhaigh et al., 2006; Hoare & Mann, 2011). Access to such knowledge was often very limited. One non-Indigenous female participant described being dismissed by a university staff member at a high school career expo after asking for information on scholarships:

‘So like at the careers expo at the Uni we were talking to … someone doing scholarships … and we’re like oh what scholarships are there? … He was like well, you’d want to get in first … (I)t was very much like oh well you’re not going to get in so like don’t bother. I was like well, like I sort of need to know if I can afford it … He just really wouldn’t help us’.

Participants spoke about their family’s attitude towards education. Some participants indicated their parents were very encouraging during their schooling and of their aspiration to go to university and to pursue medicine. Others described their family’s indifference to them going to university or getting into medicine. For example, a non-Indigenous female stated that her family were still not ‘crash hot’ on her studying medicine as they ‘didn’t know if it was the best idea’ or ‘whether (she) was suited to it’. A more common narrative was one of family support regardless of what post-school work or education option was chosen:

‘(My family) were pretty good with anything really. They were, yeah happy for me to go to Uni or to get a job or like it didn’t really matter as long as I wasn’t sitting at home not doing anything’ (non-Indigenous female).
'Look my family are – they think it’s a good idea (to study medicine). My mum says, “Do what you want to do”, but whatever makes you happy … But some of my uncles … think … it’s a good thing to do … (It’s a mixed response’ (Indigenous male).

These family attitudes resonate with Lareau’s (2002, 2003) cultural logics of child-rearing. Lareau argues that the attitudes and practices of working-class parents are guided by a logic of spontaneous natural growth and that this contrasts with a logic of concerted cultivation held by middle-class parents. Concerted cultivation is premised on parents’ purposefully engaging their children in activities which lead to cognitive, social and cultural development. While participants do tell stories about their parents being ‘proud’ of their decision to go to university (and in some cases to pursue medicine), the main emphasis in these narratives is on parents being happy if the child is happy and productive, rather than on the accrual of academic accomplishment or status.

‘Man, I grew up poor. Just because I’m studying doesn’t mean anything’: difference and medical education

One of the most significant barriers to medical education, besides the complicated and expensive application process (see Brosnan et al., 2016), were personal feelings of ‘not being good enough’ or ‘smart enough’ to be a doctor. One non-Indigenous woman described medicine as a ‘big sanctimonious kind of thing’ that seemed ‘too big’ for her. The idea that medicine was the ‘big’ degree, accessible only to the right type of people was a common theme:

‘I thought it was something kind of distant. Like ahhh medicine, you know that’s sort of unattainable’ (non-Indigenous male).

‘To be honest I did not think I’d get into med. I’d kind of given up. I always did well at school but my ATAR (Australian Tertiary Admission Rank) was 97 … and that was kind of all we knew about it’ (non-Indigenous female).

‘I guess I just didn’t see myself in that class of people, because in my mind they were a different class … (It was something I wouldn’t dare to dream’ (non-Indigenous female).

These feelings of inadequacy are more than individual self-perception. They point to a collective characteristic of FiF medical students: a shared understanding that certain groups are not really ‘entitled’ to aspire to medicine, even if they have demonstrated significant academic achievement and life accomplishments. Indigenous participants were especially explicit in naming how social class and racism influenced their sense of entitlement:

‘Yeah well at first I thought I didn’t realise I was good enough to get into something like medicine … No one in my family has ever done anything like that before … (Having the background I have too, being Aboriginal, you don’t really feel like you’re entitled to something as good as this’(Indigenous female).

‘I think the main thing was lack of belief in myself … Because…the medical degree is fairly elite – well you get a lot of people in medicine that have come from very wealthy families … and (a)re very confident. I felt I wasn’t smart enough’(Indigenous male).

Once in medical school, most participants describe a growth in self-confidence. A few, however, said that they still had ‘imposter syndrome’ (Clance & Imes, 1978). Almost all participants expressed enthusiasm for studying medicine and presented a
picture of the intense socialisation process associated with medical education, a phenomenon that has been documented in previous studies (Becker, Geer, Hughes, & Strauss, 1961/2009; Fox, 1979; Lempp, 2009). Most saw themselves as part of the ‘med family’ or a close-knit group similar to ‘high school’. They expressed genuine affection and respect for their peers who were from different sociocultural backgrounds:

‘(S)ome of (the other students have) both got parents as doctors … I don’t know you sort of get the vibe from them that they feel like it’s their right to be there or whatever. But that’s not so much, because I have a lot of other friends who have (a parent) as doctors who are just completely down to earth about it … You just get the occasional person who is … a little entitled about it’ (non-Indigenous male).

‘I guess I expected them (other medical students) to be a lot more arrogant and some of them are, don’t get me wrong … There are a lot of people from (a wealthy area of Sydney) and this sort of people from the doctor’s pedigrees and that sort of thing, but they didn’t come with at least as much arrogance as I would’ve thought’ (non-Indigenous female).

Some participants offered extended reflections on how social class and cultural difference manifested in medical education contrasting themselves with the ‘legacy kids’ – a term used to describe students whose parents were doctors. These evoked strong emotions:

‘I do find it hard to relate to people that are from rich families … because there are a couple that are older that are from well-off families and I can be pleasant to them … But I just don’t go out of my way to have a conversation with them …. I don’t know, there are all these things that I’ve seen and done that are different to what they may have seen and done … (M)aybe I’m jealous that they had all that stuff that I never had … and (they) just have this kind of easy great life’ (non-Indigenous female).

Participants gave examples of the social, economic, and symbolic ‘distance’ (Klein, 2015) that existed between them and their more privileged peers. Some spoke about the difference between their rural upbringing in contrast to city dwellers. Attendance at prestigious private schools in the city was a key symbolic marker of social class. Financial hardship could affect social opportunities and feelings of belonging and sometimes created a stressful, even demeaning, university experience:

‘I guess values wise, like I hate being in debt to people. Like I don’t like borrowing money. My nan rings up sometimes and says, “Do you need $20?”, and I’m like “No nan, it’s fine.” Like I’d rather just not eat for the day or something … (P)articularly in that first year I was … having to pay rent for the first time and like setting up electricity and getting a phone … and getting a car … I ended up having to borrow money from one of my friends and it was just the worst ever. Like obviously I could have worked more if I wasn’t doing medicine, and so part of me was … I should take another year off … and figure myself out, and I’d end up being like, “No, it’s stupid. You’ll pay her back and it’ll be fine.” But yeah, I felt kind of dirty after that’ (non-Indigenous female).

Indigenous students detailed the distinct socio-economic and cultural distance between themselves and some of their peers:

‘I think with medicine there’s a lot of big fish and I think they’ve come from a school where they’re the smartest person, and a lot of them have come from … quite high socio-economic backgrounds, so they’ve been given quite a lot … Like a lot of people are quite clueless with Indigenous health. I don’t know if that’s their fault though, or if they just
haven’t been exposed to it. A lot of them are genuinely nice people. It’s just their upbringing has probably made them a bit ignorant’ (Indigenous female).

Some Indigenous participants pointed to language as a marker of difference. An Indigenous female participant recounted how people changed the way they spoke to her when they found out she was studying medicine, with her response being: ‘Some people take me as a snob and I’m like, ‘Man I grew up poor, just because I’m studying doesn’t mean anything … and it’s like, I don’t speak proper’. Another Indigenous woman commented:

‘(B)ecause we go to straight out into hospitals when we’re learning effective communication skills with patients, so definitely my communication skills have improved heaps just because I have a structured way of talking now. I feel like yeah like so (I) can talk to people a bit better …. I think it’s an improvement anyway because before (at home) we talked a lot of broken English’.

From not speaking ‘proper’ or in ‘broken’ English (possibly a reference to Aboriginal English), to the use of the self-deprecating label ‘bogan’ or the use of self-diminishing terms like ‘dirty’, the language of participants served to delineate and sometimes defend social and cultural difference. Language created solidarity with family and community of origin, as in the case of the non-Indigenous male student who described his pride in being able to talk about ‘ordinary things’ like the football and in acknowledging patients by using the working-class greeting, ‘G’day mate’. The desire not to be seen as socially superior was evident in some participants’ choice not to disclose their status as medical students in social situations because they said that people assumed that they were ‘going to look down on them or something’.

Some participants did use language that reflected a sense of diminishment. For example, a non-Indigenous female participant still saw herself as ‘a bit of a scummo’ while another described herself as ‘a bit rough around the edges’, and yet another as ‘not very polished’. This was in contrast to other medical students who were viewed as ‘a different breed’ or different ‘calibre of people’, ‘pretty clean cut’, ‘a lot more polished’, ‘bright’ and ‘highly intelligent’. This use of descriptors to differentiate the (less privileged) self from other (more privileged) students resonates strongly with Ashley et al.’s (2015) observations on the equation of talent with ‘polish’ in elite professions.

Stories about overt stigmatisation or Othering due to social class and/or cultural difference were rare, although two episodes were disclosed:

‘It kind of focuses you when you go into a group of people who you realise are – like they’re just like “What do your parents do?” When you’re like the only one whose dad’s a bartender and not like been to uni or anything … (L)ike it always surprises people … I actually had one girl in our year say to me – I don’t know, we were talking about something, and then she looked at me and she said, “Yeah but you’re poor”, and I was like “Excuse me! That’s not appropriate”’ (non-Indigenous female).

‘This week has actually been funny. We had a few lectures on public health and social determinants of health … and we had this long lecture and they were giving us examples. First there was a girl and she was perfect, grew up in a perfect family and was rich and had wonderful opportunities and was loved and went to high school and now she’s us. And I’m like “Okay”. Then the other one was this little boy who was growing up and his mother was a heroin addict and … he ended up in jail. And (the lecturer) was like, “See, so you’re all privileged and you don’t know these kinds of people”, and I’m like, “Hmm, I was that
little boy, but okay.” Then it sparked quite a lot of conversation in the tut(orial) and everyone was … like, “We’re never going to meet these people.” I didn’t say anything. I bit my tongue’ (non-Indigenous female).

Goffman (1963, p. 3) suggests that stigma works as a ‘language of relationships’, a social sharing of attributes that are used to discredit certain identities. The labelling of the student as ‘poor’ is a strategy of devaluation and, although it is resisted, serves to mark someone as a member of a ‘lesser’, discredited social class (Goffman, 1963, pp. 145–6). The second story, which highlights a powerful yet incorrect assumption about the composition of the student body (Beagan, 2005; Granfield, 1991), illustrates how individuals manage potentially discreditable information about themselves. Goffman (1963, p. 73) calls this self-management strategy ‘passing’. While some participants do describe when and how they reveal their sociocultural backgrounds, others manage their potentially discreditable identities by deciding to bite their tongues. In Fraser’s (1998) terms this narrative provides a glimpse into the ordinary ways that academics can fail to recognise social difference in their classrooms. It is an example of how ‘class and status map perfectly onto each other’ (Fraser, 1998, p. 6), as the academic teaching the class misrecognises it as socially elite rather than comprising, if in a small way, social difference.

Participant narratives reflected a complicated language of relationships, some stigmatised, others resistant to stigmatisation. As the work of Douglas (1966) illustrates, metaphors denote a systematic ordering and classification of what matters within the social realm. Feeling ‘dirty’, ‘scummo’, ‘rough’, ‘not polished’, not smart enough, or feeling your ‘broken’ language inadequate, or going to a ‘dero’ school, being called ‘poor’ or a ‘drop-out’, all imply a diminishment of working-class and Indigenous sociocultural backgrounds. In education, this profound sense of diminishment is called the ‘deficit perspective’ (Gorski, 2011). The struggle over ‘fit’ for non-traditional students in higher education is well documented (Lehmann, 2014; Reay et al., 2010), where it is sometimes conceived of as a mismatch of habitus (Bourdieu, 1977). The social mobility narratives of the FiF students in our study elucidated the concept of ‘fit’ as an inner and social dynamic of continual meaning-making and negotiation described by Reay (2005) as a ‘psychic economy’. The psychic economy of our participants involved finding a genuine place in the elite ‘polished’ world of medicine for those who were ‘a bit rough around the edges’ (Reay, 2005). It is to the area of negotiating professional identity and future prospects in the medical profession that we now turn.

‘It’ll make me more fulfilled, but it won’t make me snobby’: professional identity and future prospects

Participants recognised the very high status of the medical profession and the prestige associated with being a doctor. Status was not just related to financial rewards but, as one male participant put it, to the moral respect associated with the profession: ‘I think the idea of being a doctor sort of holds trust or … gives you some kind of moral compass for society’. Some expressed discomfort with this sense of prestige saying that could not get used to being a ‘higher person in society’.

Some participants described tensions in their emerging professional status. An Indigenous female student described the ‘absolute disbelief’ expressed by other doctors
when they found out that her partner was not a doctor but a tradesperson. Another revealed how she initially felt conflicted when returning to her community of origin:

‘A lot of them are like drug dealers and things, like they’re not exactly a higher moral standing people. I love them to death and they’re really generous and lovely, but they like to do illegal things and I can’t exactly turn my back on them … I thought it would be a really awkward thing to tred. But my sister recently started dating a guy who has a friend who’s a doctor, who’s the first doctor I’ve met outside of medicine (and) his friends are all kind of in that same sort of group and he manages it fine. Like he just makes sure that they don’t do anything illegal around him … and he does his best to try and influence them in a positive way. So if he can do it (being a doctor), I’m sure I’ll do fine’ (non-Indigenous female).

While participants viewed their upward social mobility as positive, many stated that they would like to remain rooted to their original milieu (cf. Lehmann, 2014). Indigenous participants spoke about being a ‘good role model’ for young Aboriginal people and of returning to their ‘mob’ to improve Indigenous health outcomes. Others spoke about medicine as a ‘service’ and of working in communities of need:

‘(W)e actually have this responsibility to use this position of privilege that we have to make a difference in the world … (A)ctually my identity isn’t at all about … my status or position or career … It’s very much living … in service of other people’ (non-Indigenous male).

‘(B)eing a doctor doesn’t really mean it’s great and it’s grand and it’s fantastic. But I think it’s more of what you can do with it rather than getting the status …’ (non-Indigenous male).

The idea of melding parts of sociocultural identity with professional identity was very important to some participants. A number considered the knowledge and dispositions derived from their sociocultural backgrounds (or their original habitus) as a vital part of their professional identity:

‘I am … (v)ery humble, low socioeconomic status, surrounded by people who typically have low levels of education, low levels of money, poor health … I understand (where patients are) coming from … I understand why it might be a health disaster because there’s the cigarettes and there’s the Centrelink (government welfare) benefits don’t pay very much … I’ve lost my job … Yeah I understand it’ (non-Indigenous male).

‘(Other students) get shocked when I talk about … where I live at the moment … The whole opposite side of the street has now become (public) housing … so I see a lot of shit … That’s hopefully an advantage … So I might have to be a slightly more refined version of myself as a doctor. But I think with the patients I’ll still be okay and with my family, I’ll still be much the same’ (non-Indigenous female).

An important tactic in the construction of such ‘humble’ professional identities is maintaining an ‘anti-pretentiousness’, a common characteristic of working-class cultures (Skeggs, 2004, p. 114). The social mobility journey involved participants affirming aspects of their social and cultural identities that are often not associated with the rarefied world of medicine (or other high-status professions [Ashley et al., 2015]), such as: being ‘humble’; not being ‘fancy’; genuinely knowing how ‘hard’ life can be; and viewing the ‘shit’ of the everyday life as personally and professionally valuable.
Conclusion: observations on extreme social mobility

Social mobility is a journey of sights, transitions, encounters, dangers, desires, costs, acquisitions, and destinations. Travellers move through new physical, social, emotional, and cultural spaces, navigating landscapes of shifting selfhood, as they interact along the way with strangers and familiar others. Reay (2013) captures possible social and subjective implications of the journey when she writes:

‘Social mobility is a wrenching experience. It rips working-class young people out of communities that need to hold on to them, and it rips valuable aspects of self out of the socially mobile themselves as they are forced to discard qualities and dispositions that do not accord with the dominant middle-class culture that is increasingly characterised by selfish individualism and hyper-competition’ (p. 667).

Reay’s perspective extends on previous scholarship which has highlighted the ‘hidden injuries’ of social class where notions of ability and talent are considered as a natural ‘badge’ of the (middle class) individual rather than as characteristic of working-class people (Sennett & Cobb, 1972/1993, p. 59). The literature suggests that upward mobility entails an often arduous claiming of these ‘badges’ while simultaneously managing potentially stigmatised or discreditable identities (Granfield, 1991). This can create feelings of identity ambivalence. Lehmann (2014) suggests that sometimes this unease is so intense that upwardly mobile working-class university students can begin to echo the ‘middle-class chorus that renders working-class knowledge and experience deficient if not pathological’ (p. 13).

Participants in our study were very aware of their social and cultural difference within the context of medical education, and some had experienced ambivalence about their new-found social status. However, their narratives point to a more tactical refinement of self rather than a ‘forced’ discarding of working-class and/or Indigenous identities. By refinement we do not necessarily mean becoming more ‘polished’ in a middle-class dispositional sense or of joining a ‘middle-class chorus’ to denigrate family and community of origin. The narratives in our study are not about radical transformation, where aspects of the self are ‘rip(ped) out’ and replaced. Rather, they reflect a tactical incorporation (in a conscious and an embodied sense) of certain middle-class attributes, coupled with an articulated appreciation of the worth of what they can bring to a very exclusive table. These stories articulate how the knowledge, language and dispositions derived from social and cultural backgrounds will be of great value when the student arrives at their new destination, the medical profession.

As the medical students in our study were mainly in the first and second year of the degree, perhaps the most interesting question is whether they will sustain this process of tactical incorporation into their professional careers. Furthermore, we acknowledge that a limitation of the study is its single site and cross-sectional design. Cross-institutional and international comparative studies, and those with a longitudinal design that focus on the post-graduation experiences of students, are required to more deeply explore the issue of intersections of social difference and extreme social mobility, and its effects on educational experience and professional identity formation. This said, the narratives do indicate a genuine sense of recognitive social justice (Fraser, 1998), a concept that describes the power of marginalised social groups to identify their own strengths and gain a sense of their agency in addressing oppression (Gale, 2000). In Fraser’s (1998) terms participants recognise and affirm their sociocultural
strengths while simultaneously experiencing the stigma of discreditable identities and living a distinct sense of difference. Their experiences suggest that school and university educators may need to reflect on how they recognise social difference beyond and against dominant social norms in order to remake a ‘difference-friendly’ (Fraser, 1998, p. 1) education system.

The ‘price of the ticket’ of social mobility, it’s hidden and open injuries, are manifest in encounters with peers who might stigmatise, with Faculty that ignore the (limited) diversity of the student body, and in the subjective grappling with feelings of not being ‘smart enough’ or ‘entitled’ enough to be a doctor. Despite this, the often protracted and difficult journeys of our participants into and through medical education attest to their talent, tenacity and, to use a working-class phrase, an admirable capacity to ‘roll with the punches’.

If, as Parker (2016) suggests, universities have a direct role in redistributing the ‘spoils of higher education’ and disrupting ‘patterns of inherited advantage’, then closer attention should be paid to the exceptional cases of FiF students in high-status degrees. The social mobility journeys of such students provide unique insights into the ways inequality and stigma inhabit educational settings and, perhaps more importantly, the creative adaptations of selfhood that allow some to succeed against significant odds. Journeys of extreme social mobility are not just about linear pathways away from family and community of origin (Reay, 2013). Instead, these journeys are often meandering paths involving great humility, a desire to maintain pride in one’s roots and, for many, an intention to keep travelling back to family and communities of origin, for love and professional service.

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