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Disrupted and Reconstructed Legitimacy Among Widening Participation Medical Students

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Abstract

Background

Widening participation (WP) initiatives have improved access to medical education, yet less is known about how WP students experience legitimacy, participation, and identity formation after entry. Existing models often conceptualise professional identity formation as a linear process, overlooking the instability and structural constraints that may shape WP students' trajectories.

Methods

This qualitative participatory study used a student–researcher partnership to centre WP student perspectives. Medical students in preclinical years (Stages 1 and 2) who had entered the programme via a gateway year participated in peer-facilitated online focus groups. Data were transcribed and analysed collaboratively with student researchers using reflexive thematic analysis.

Results

Reflexive analysis demonstrated that legitimacy was not conferred at entry but continually negotiated through participation for WP medical students. The hidden curriculum and informal norms regulated access to participation, with WP students disproportionately affected by limited cultural and social capital. Structural inequities extended beyond access, shaping engagement in extracurricular and career-building activities and contributing to burnout. Despite this, students demonstrated significant agency, reconstructing identity in ways grounded in personal values and commitment to medicine, often at personal cost.

Discussion

We propose a model of disrupted and reconstructed legitimacy comprising four iterative phases: emerging legitimacy, destabilisation during transition, constrained participation, and identity reconstruction through agency and purpose. These findings challenge deficit narratives and extend identity formation theory by emphasising contingency, disruption, and structural context. Participation emerges as a key mechanism through which legitimacy and confidence are produced, rather than inherent individual traits.

Background

Despite decades of widening participation (WP) initiatives, medicine remains one of the least socioeconomically representative professions in the United Kingdom, with students from more advantaged backgrounds continuing to be disproportionately represented within medical schools (1, 2).

Recent analysis of nearly 94,000 UK medical school applicants found that students from the lowest socio-economic backgrounds accounted for just 5% of entrants between 2012 and 2021, while 75% came from higher socio-economic backgrounds, despite the proportion from the lowest group having more than doubled over this period (3). This persistent underrepresentation repeatedly identified by the Sutton Trust raises concerns regarding equity, social accountability, and the ability of the medical workforce to reflect the populations it serves (3). In response, medical schools have increasingly adopted contextual admissions and gateway programmes to broaden access for students from underrepresented backgrounds (4, 5). These efforts have yielded measurable progress; the proportion of entrants from the most deprived areas (IMD quintile 1) has risen from 6% to 14% over the past decade, while state school representation has increased from 47% to 54% (6).

The University of Plymouth, Peninsula Medical School serves a region characterised by socioeconomic deprivation, educational disadvantage, rurality and coastal communities, making widening participation a central component of its social accountability mission. To address the limited socioeconomic diversity of its student population, Peninsula launched its Bachelor of Medicine Bachelor of surgery with Gateway Year programme in 2018–2019. The programme provides an additional preparatory year to support students from WP backgrounds in developing the academic, personal and professional foundations required for successful progression into the undergraduate medical curriculum. Since its introduction, the programme has expanded substantially and now contributes approximately one-quarter of the annual year one intake.

Institutional data demonstrate a marked shift in the socioeconomic composition of the medical student population following the introduction of the Gateway programme (Fig. 1). Representation from students living in more deprived Index of Multiple Deprivation (IMD) deciles has increased considerably, suggesting that the programme has broadened access to medicine for students from socioeconomically disadvantaged backgrounds. However, changing who enters medicine does not necessarily change how medicine is experienced.

Figure 1: **2025/2026 Index of Multiple Deprivation Data from Peninsula Medical School.** Data from the 2025/2026 academic year show that students entering Year 1 via the Gateway programme were more commonly from lower IMD groups, whereas standard-entry students were more commonly from higher IMD groups. When these cohorts were combined, the resulting Year 1 intake demonstrated a more even distribution across IMD groups. The figure also highlights the differing socioeconomic profiles of students entering through these two routes, recognising that IMD represents one indicator of disadvantage rather than a direct measure of individual circumstances.

While gateway programmes can increase access to medicine (7, 8), WP students may continue to encounter challenges relating to belonging, confidence, social capital, financial pressures and engagement with opportunities that support academic and professional development (9, 10). These experiences are important because medical education is not solely a process of acquiring knowledge and skills. Learning, identity formation and progression occur through participation in educational and

clinical communities, where opportunities to engage, contribute and be recognised as legitimate members shape students' sense of belonging and professional development (11, 12).

Emerging evidence suggests that WP students frequently balance competing demands, including financial responsibilities, employment, family commitments and academic workload (9, 10). While financial pressure affects medical students broadly, with a 2025 British Medical Association survey finding that 90% felt their funding did not cover living costs (13), it falls unequally. A UK survey comparing WP and non-WP students found that WP students were significantly more likely to feel limited by their finances, to feel that paid work impacted their studies, and to report that their personal background adversely affected their mental health (10).

These pressures may accumulate over time, contributing to emotional fatigue, burnout and a sense of “survival mode” rather than full engagement with the learning environment (14, 15). Burnout is common among medical students generally, with a meta-analysis of 24 studies estimating its pooled prevalence at 44.2% (16). WP students report financial strain and reliance on paid work at significantly higher rates than their peers (17). WP students report greater financial strain and are significantly more likely to report that paid work adversely affects their studies. They also report poorer mental wellbeing related to their background, factors that may contribute to burnout (10). Furthermore, participation in dominant social and cultural practices within medical school, such as alcohol-centred social activities, may be inaccessible or exclusionary for some students, further shaping their sense of belonging and professional identity within the profession (18, 19, 20).

Although WP initiatives are frequently evaluated through admissions, retention and progression outcomes, less attention has been paid to students' experiences after entry, particularly within established Gateway programmes that have demonstrably altered cohort demographics. As the first Gateway cohorts at Peninsula Medical School have now graduated, an opportunity arose to move beyond questions of access and explore how WP students experience medical education following admission. Furthermore, as government policy shifts towards allocating new medical school places primarily to WP students (21), the need for a stronger evidence base becomes increasingly important.

There is a need to better understand the personal journeys of these students, including the challenges they face, the sacrifices they make, and the ways in which they persist within an often-inequitable system. Although WP students are often praised for their resilience, this discourse may obscure the structural conditions that necessitate such adaptation. In line with Pierre Bourdieu’s theory of capital, medical education continues to privilege students with pre-existing cultural and social capital, with the hidden curriculum reinforcing inequalities in access to opportunities, belonging, and professional identity formation (22). Therefore, obscuring the structural conditions that necessitate such resilience in the first place (23).

There is increasing recognition that WP efforts should extend beyond admission to understand and support students throughout medical school and into postgraduate training (24). This study seeks to address these gaps by exploring the personal journeys of WP medical students who have progressed

through a Gateway year and are now navigating the undergraduate medical programme. Drawing on qualitative data from student-led focus groups, this paper examines the interconnected themes of struggle, sacrifice and persistence within medical education. By foregrounding students lived experiences, this research moves to highlight the structural and relational factors that shape WP students' trajectories. We sought to understand how WP students navigate medical education and what these experiences reveal about the development, disruption and reconstruction of legitimacy within medical education.

Methods

Study design and methodological orientation

This qualitative participatory study was informed by an interpretivist epistemology, recognising meaning as socially constructed. A student–researcher partnership positioned WP students as active contributors to knowledge production, addressing the marginalisation of WP voices and redistributing epistemic authority. Analysis was sensitised by concepts of belonging and educational transition.

Co-creation of the focus topic group guide

WP student partners and academic researchers co-developed the focus group topic guide, drawing on lived experience of transition from gateway year to the undergraduate programme. Through iterative discussion, open-ended prompts were designed to elicit reflective accounts while ensuring sensitivity. The guide was reviewed collectively for clarity and relevance (Appendix A) (Fig. 2)

Participants and recruitment

Eligible participants were medical students in stages 1 or 2 (preclinical years) who entered via a WP Gateway year. WP status was defined by institutional criteria requiring multiple indicators of disadvantage, including socioeconomic (e.g. free school meals, Educational Maintenance Allowance, UKCAT bursary, Index of Multiple Deprivation deciles 1–4,), educational (low-performing school), and social factors (care experience, refugee status, low participation POLAR4 area, or regional underrepresentation such as South West England).

Invitations were distributed via cohort-wide mailing lists by academics to ensure equitable access. Participation was voluntary; 13 students participated across three focus groups (Year 1, n = 9 across two groups; Year 2, n = 4 in one group).

Detailed demographic data was not collected to avoid over-categorisation and align with the study's interpretivist and participatory orientation. Participants introduced relevant aspects of identity during discussion where meaningful.

Consent was obtained via Jisc. Participants could withdraw within the two weeks following the focus group and received a £20 voucher.

Data collection

Three online focus groups (Microsoft Teams) were conducted and lasted ~ 90 minutes each.

Sessions were facilitated by a trained WP student partner, with no academic staff present to minimise hierarchy. Training in facilitation and qualitative analysis was provided by experienced researchers. Peer facilitation may have shaped disclosure through shared identity, assumptions of common understanding, and social desirability.

Sessions were audio-recorded, transcribed verbatim, anonymised, and checked for accuracy by student partners.

Data analysis

Data were analysed using Reflexive Thematic Analysis, consistent with an interpretivist, participatory approach.

Five researchers (two student partners, three academics) collaborated in analysis. Student partners led familiarisation and inductive coding. Codes were organised in Microsoft Excel.

Analysis proceeded iteratively from coding to theme development and refinement across the dataset. Coding was not treated as a reliability exercise but as analytic engagement. Student partners contributed as equal contributors to interpretation, with academics providing methodological guidance. Divergent interpretations were explored rather than resolved. Themes were developed as interpretive constructions capturing shared meaning while preserving complexity.

Reflexive dialogue was embedded throughout. Rigor was enhanced through collaborative analysis, reflexivity, and sustained engagement with the data.

Researcher reflexivity and positionality

The team comprised WP student partners and academic researchers with differing relationships to WP. Student partners contributed insider perspectives; academics provided methodological expertise and critical distance. These positions shaped interpretation: insider status facilitated rapport but risked assumed understanding, while academic distance enabled critique but risked contextual misreading. Reflexivity was embedded throughout.

Ethical considerations

Ethical approval

was obtained from the University of Plymouth Ethics Committee (4910). Participation was voluntary and did not affect academic progression.

Participants received PI contact details, and sessions were held during core hours to ensure access to support. Students received a participant information sheet prior to the focus group and informed consent was received prior to the focus group to enable anonymised data to be shared. Confidentiality and peer dynamics were addressed prior to discussion.

Data were anonymised and stored on secure university OneDrive, accessible only to the research team. Audio files were deleted after transcription. Data will be retained for 10 years in line with institutional policy, then permanently deleted. Students had two weeks following the focus group to have their data removed from the transcripts if they changed their minds around the information they had shared.

AI Disclosure

University of Plymouth AI-assisted writing tools (Microsoft 360 Co Pilot) were used to support drafting and language refinement. All content was reviewed and verified by the authors.

Presentation of quotations

Participant quotations were lightly edited to improve readability by removing non-lexical utterances (e.g. "um", "uh", and "erm") where these did not alter the meaning of the statement. Ellipses (...) indicate natural pauses in speech, while square brackets with an ellipsis ([...]) denote the omission of text that was not relevant to the reported findings. All edits were made without changing the meaning or intent of participants' responses.

Results

Theme 1: Entering medicine with emerging legitimacy

Students described the Gateway year as a critical context in which they began to develop a sense of legitimacy as participants in medical education. Structured pedagogical approaches, particularly small-group enquiry-based learning (EBL), which include preparation for whole-cohort presentations, were experienced as normalising active participation and enabling early engagement.

“It [the way EBL sessions were run] helped us build a lot of confidence… we had to present in front of big big groups like the whole cohort.” (Participant 1, Year 2)

Through repeated exposure to these environments, students described developing communication skills and a growing sense that they could “take part” in the practices of medical training. This early participation appeared to underpin an emerging sense of belonging.

For many, this translated into increased confidence on entry to Year 1, particularly where continuity of peer relationships provided a sense of familiarity.

“I wouldn’t be confident this year at all if I hadn’t had foundation [Gateway] year, and also the people we meet – it was good to come back and see familiar faces, and have that little extra support.” (Participant 1, Year 1)

Students also articulated motivations that contributed to this emerging legitimacy, including aspirations shaped by personal experience, family influence, and a desire to contribute meaningfully to others.

“…the doctor in the hospital then was called Doctor [Surname], which was my surname. So I said I want to have that said. I want to be, I want to be Doctor [Surname].” (Participant 3, Year 1a)

However, for some, these aspirations coexisted with uncertainty about belonging within the profession.

“If I'm going to be so real with you, it's [realising I wanted to be a doctor/pursue this career] because I watched Grey's Anatomy. If I'm being so real with you. Do I see it in the future? Me being a doctor? If I'm also being so real with you – no.” (Participant 3, Year 1)

These accounts suggest that entry into medicine was characterised by an initial, but still fragile, sense of legitimacy.

Theme 2: Negotiating outsider status within the medical community

Transition into the main medical programme from the Gateway year was consistently described as a destabilising experience in which students' sense of legitimacy was challenged. Participants described a shift from smaller, supportive learning environments to larger and more competitive contexts, where participation became more difficult and socially risky. These experiences are consistent with previous research demonstrating that students from WP and first-in-family backgrounds often experience uncertainty, outsider status, challenges to belonging and confidence, and difficulty navigating the social and cultural norms of medical education during key educational transitions (25, 26).

…you're coming into a big group now, of people you don't know, people who got A*'s, very loud personalities [...] They very much want their voices heard so it can be a little bit hard to interject, and also the confidence to ask for help when things are getting a little bit difficult.

(Participant 2, Year 1)

This shift was associated with increased self-monitoring and fear of negative evaluation, leading to hesitancy in contributing to group discussions.

…it's really overwhelming thinking that everyone's here in front of you, they're smart and know their things, and you're not really sure of your things, having to be in front of them, just waffling a bit and

hoping that no one's judging you for what you're saying.

(Participant 1, Year 1)

Some students described a perceived culture in which avoiding error was prioritised over participation.

…you know when people [lecturers] ask questions, and they want people [students] to talk, no one will speak, for the reason that everyone is afraid of each other. They don't want to seem wrong; they don't want to seem stupid

(Participant 4, Year 1)

These experiences extended beyond the classroom into clinical and informal learning environments, where students described uncertainty about their role and presence.

I think that with shadowing doctors, I really don't like it, I really think I'm bothering them.

(Participant 3, Year 1)

Peer interactions further shaped this sense of outsider status. While relationships formed during the Gateway year were described as supportive, however when moving into Year 1 interactions with peers were sometimes experienced as competitive or exclusionary.

…literally three weeks into uni, I asked somebody for some help, and they said 'no, we can't help you because, we're going to take the same exam; if I help you, you're going to get the answer'. I was like, 'okay, I'm going to go ask my [Gateway] year friends instead'. I think that confidence can be knocked by small things like that.

(Participant 2, Year 1)

Participants frequently described imposter syndrome (27), particularly during early transition, characterised by comparison with peers and uncertainty about their academic standing.

Okay, the thing that I struggled with the most, and it's still there, was imposter syndrome. It's like, when you look around, especially in the beginning, when you look around, there's so much content, you just see people studying all the time…

(Participant 5, Year 1)

Taken together, these accounts suggest that entry into the wider medical community involved an ongoing negotiation of belonging, in which students oscillated between participation and marginality.

Theme 3: Structural disadvantage constrains participation

Students described how structural constraints, particularly financial pressure limited their ability to participate fully in both academic and extracurricular aspects of medical education. Many participants

reported undertaking paid work alongside their studies out of necessity.

I'm having to... working lots of jobs, and, you know, lots of side hustles in the summer. I'm having to work, and, just to try and save as much money as I can, because I don't know what's coming

(Participant 3, Year 2)

Employment demands were described as extending into term time and vacation periods, reducing time available for study, rest, and engagement with the wider student community.

I have to work over the summer, and even during the term time next couple of years, I think I'll have to continue working the weekends in order to be able to just live. Which is quite a big struggle, considering we do need that sleep, we do need that time to study…

(Participant 1, Year 2)

Participants emphasised that these pressures were not temporary but persisted throughout training.

“…there's reasons we come into Gateway year, as you guys have already said. And that doesn't stop once we get into year one. Those reasons, but in the background, … still persist. And those are the struggles we have to contend with” (Participant 2, Year 2)

Financial constraints also limited access to extracurricular opportunities considered important for career progression, including research and clinical exposure.

"I'll be spending this time where I know I can even do extracurricular stuff [...] maybe even getting involved in research, or shadowing someone who [...] is doing a specialty that I enjoy [...] I can invest that time in making my future opportunities a bit better [...] the fact is, I just can't do it, because I have to pay for things. No one's gonna pay for your bills, or for your rent, and you're just forced into that situation." (Participant 3, Year 2)

These limitations contributed to unequal access to experiences through which students build professional identity and career capital. In addition, ongoing uncertainty about funding contributed to broader insecurity.

“There's no absolute. Like, no one has ever, like, told us what's gonna happen next when that funding is, like. Like, I heard about the NHS bursary, I don't know how much they're gonna pay me. I don't know if they're gonna pay for my tuition or not, or, like, they're gonna pay for my maintenance, how much are they gonna pay me?” (Participant 3, Year 2)

Burnout emerged within this context as a cumulative and structurally mediated experience. Students described the interaction of academic workload and financial pressure as producing exhaustion and reduced capacity for engagement.

I had to, uh, work a lot during term time, and then trying to keep up with the content while working night shifts, and then. I think I was very burnt up, I couldn't focus in the mornings at all in any of the lectures.

(Participant 1, Year 2)

Time inequalities between students were also perceived as significant.

If you compare my week to someone else who didn't have to, wasn't forced into the situation. They would have a lot more time to study, to catch up on sleep, to do so much more.

(Participant 3, Year 2)

These findings suggest that structural disadvantage constrains not only academic engagement but also access to the broader experiences that support integration into the medical community.

Theme 4: Reconstructing identity through persistence and purpose

Despite these challenges, participants described actively reconstructing their sense of identity and belonging within medicine. Over time, some students reported developing strategies to navigate the social and academic demands of the programme.

“…since being a foundation [Gateway] student you kind of have to fight your corner a little bit in first year.” (Participant 2, Year 1)

Motivation played a key role in sustaining engagement, often rooted in personal values, lived experience, and a desire to contribute to others.

“I just wanna, sort of, pursue this career to help more people, and also, support people who come from backgrounds like myself.” (Participant 1, Year 2)

For some, aspirations were shaped by experiences of adversity, informing future career goals.

Because of my background with war and being in it, I'm really, really passionate about humanitarian work. In terms of specialties, for me, knowing that I want to go into humanitarian work, it would probably be emergency medicine or surgery [...] where I can really help people in places of war, and natural disasters and things like that.

(Participant 3, Year 2)

Students also described motivations linked to social mobility and intergenerational opportunity.

“You know, my parents worked minimum wages jobs. I liked the idea of actually being able to support myself […] I have this really great opportunity to be able to do something that my parents couldn't do.” (Participant 2, Year 1)

These accounts suggest that, while structural and relational challenges persisted, students actively constructed meaning and purpose within their experiences. Identity formation was therefore not linear but involved ongoing reconstruction in response to both enabling and constraining conditions.

Across the data, WP students' experiences of medical education were characterised by a dynamic process of gaining, losing, and reconstructing legitimacy within the medical community. Early opportunities for participation supported the development of an initial sense of belonging; however, this was frequently destabilised during transition into the main programme.

Subsequent experiences were shaped by the interaction of relational dynamics and structural constraints, which influenced students' capacity to participate fully in academic, social, and professional domains. Despite these challenges, students demonstrated active strategies of adaptation and persistence, highlighting the ongoing negotiation of identity within medical education.

Discussion

A model of disrupted and reconstructed legitimacy

Our findings suggest that WP students enter medical education with an emerging sense of legitimacy, developed through structured participation in the gateway year (11, 28). This aligns with sociocultural theories of learning, in which early engagement in shared practices supports movement from peripheral to more central participation within a community of practice (29). However, rather than progressing steadily along this trajectory, students experienced repeated disruptions to this emerging legitimacy, particularly during transition into the main programme (30).

We conceptualise this process as comprising four interrelated phases: emerging legitimacy through structured participation, destabilisation during transition and exposure to dominant norms, constraint of participation through structural disadvantage, and reconstruction of identity through agency and purpose (Fig. 3). These phases are not sequential or discrete but iterative, with students moving between them in response to changing educational and social contexts.

Figure 3. **The Disrupted and Reconstructed Legitimacy Model: WP students' iterative journey through medical education.** This model illustrates how WP students' legitimacy develops through early structured participation, is destabilised during transition into dominant medical school cultures, constrained by structural inequalities, and reconstructed through agency, persistence and purpose. Legitimacy is iterative and context-dependent, shaped by both relational and structural conditions.

This model extends existing work on professional identity formation, which has often been conceptualised as a progressive internalisation of professional values and roles (31). Our findings suggest that, for WP students, identity formation is more accurately understood as contingent and unstable, shaped by moments of exclusion as well as inclusion. In this sense, legitimacy is not granted upon entry to medical school but must be continually negotiated.

Participation, legitimacy and the hidden curriculum

Central to this model is the role of participation in mediating both confidence and identity. Consistent with communities of practice theory, participation is not merely behavioural but confers legitimacy and belonging (30). Students' accounts of hesitancy to contribute and fear of negative evaluation highlight how participation is regulated through informal norms within the learning environment (32, 33, 34).

These findings resonate with literature on the hidden curriculum, which has demonstrated how unspoken expectations and cultural practices shape students' experiences of inclusion and exclusion (35). Importantly, our study suggests that WP students may be particularly sensitive to these dynamics, as they may lack access to the forms of cultural and social capital that facilitate navigation of these norms. As a result, confidence emerges not as an individual trait but as an outcome of access to legitimate participation.

This challenges deficit-oriented interpretations of WP students as lacking confidence or preparedness, instead positioning difficulties in participation as arising from misalignment between institutional norms and students' prior experiences.

Structural disadvantage as a constraint on participation

A key contribution of this study is the demonstration that structural disadvantage operates not only at the point of access to medical school but continues to shape participation throughout training. Financial pressure, in particular, constrained students' ability to engage in both formal and informal learning opportunities, including extracurricular activities that are widely recognised as important for career progression (9, 10).

This finding extends existing WP literature by highlighting how inequities are reproduced through everyday practices within medical education. While opportunities such as research, shadowing, and networking are formally available to all students, differential access to time and financial resources results in unequal participation. In this sense, structural disadvantage limits not only academic engagement but also access to the experiences through which professional identity and career capital are developed.

The relationship between structural constraint and burnout further reinforces this point (36). Participants described exhaustion not simply because of academic workload, but as the cumulative effect of balancing study with paid employment and financial insecurity (15). This aligns with emerging evidence that burnout in medical education is shaped by systemic factors, suggesting that interventions focused solely on individual resilience may be insufficient (37).

Agency, persistence and the reconstruction of identity

Despite these challenges, participants demonstrated significant agency in navigating the demands of medical training. Students described actively reconstructing their sense of identity through persistence,

self-advocacy, and sustained motivation, often grounded in personal values, lived experience, and aspirations to contribute to others.

This finding aligns with literature emphasising the strengths and resilience of WP students, including the development of adaptive strategies and strong professional commitment (38, 39). However, our data suggest that such resilience is frequently mobilised in response to structural constraint rather than supported by the educational environment. As such, while students can reconstruct legitimacy, this process may come at a personal cost.

Implications for medical education

Across the UK, medical schools have adopted a range of approaches to reduce WP gaps, including contextual admissions, targeted outreach, gateway year programmes, near-peer mentoring, enhanced pastoral support and financial support mechanisms. The Medical Schools Council's Fostering Potential report highlights how coordinated strategies such as contextual admissions, alternative entry routes, flexible work experience requirements and targeted outreach have contributed to measurable progress, including an increase in entrants from the most deprived areas from 6% to 14% over the past decade. However, acceptance rates remain lower for applicants from the most disadvantaged backgrounds compared with their more advantaged peers (40).

Recent work by Cleland et al. exploring six newly established UK medical schools with explicit WP mandates demonstrates that institutions increasingly recognise that access alone is insufficient. Alongside contextualised admissions processes, these schools invested in personal tutoring, wellbeing services, near-peer mentoring, student-led outreach initiatives, bursaries and scholarships to support students throughout their medical education. Importantly, the authors highlight that WP policy is enacted differently across institutions and is shaped by local student populations, institutional cultures and workforce needs (41).

Our findings support and extend this argument. While initiatives such as contextual admissions and gateway programmes have been successful in broadening access to medicine, WP inequalities continue after admission through unequal access to participation, belonging, informal knowledge and career-building opportunities. Consistent with the Disrupted and Reconstructed Legitimacy Model, legitimacy was not automatically conferred at entry but continually negotiated through participation within the medical school environment. Structural inequities therefore extended beyond admissions, influencing students' ability to engage in extracurricular activities, leadership roles, research opportunities and professional development experiences that are increasingly important for career progression.

These findings suggest that WP initiatives must move beyond facilitating entry into medicine and address the relational and structural conditions that shape participation throughout medical education. Interventions should focus on creating psychologically safe learning environments, making the hidden curriculum more visible, providing mentorship across the educational continuum and reducing financial barriers that restrict engagement in career-enhancing activities.

At Peninsula Medical School, several initiatives have been introduced that align with these principles. Professional development opportunities have been embedded within the core curriculum to promote greater equity of access. Research skills are integrated throughout student-selected components, supported by conference bursaries and publication opportunities, while all students complete a quality improvement project by Year 4, ensuring exposure to experiences that are often valued in postgraduate training. The school has also sought to reduce financial barriers by promoting UK-based elective opportunities, developing local elective pathways with University Hospitals Plymouth and expanding access to bursaries and hardship funding. In addition, collaborative work with local healthcare providers aims to create employment opportunities for students, providing both financial support and opportunities to develop familiarity with clinical environments and professional expectations.

Another approach aimed at increasing confidence while building the cultural and social capital that supports successful participation in medical education is structured peer mentorship. Peninsula Medical School is implementing a multifaceted mentoring scheme with previous Gateway students now in Year 1, Year Five medical students, and clinical doctors involved in teaching. By providing role models at different stages of the medical career pathway, this approach is hoped to help students navigate both the hidden curriculum of medical school and the broader medical profession.

Alongside peer mentorship, greater awareness and understanding among medical school staff and clinical educators of the experiences of WP students is also needed. Training and reflective opportunities for educators could help challenge assumptions about student preparedness, increase awareness of structural barriers, and promote more inclusive learning environments. Together, these approaches may help reduce inequities in participation, strengthen students' sense of belonging, and support their professional identity development throughout medical school.

Strengths and limitations

This study offers an in-depth, participatory exploration of WP student experiences, with student partners contributing to design, data collection, and analysis. This approach enhanced the authenticity and relevance of findings.

However, the study was conducted within a single institution, which may limit transferability. Participants were self-selecting and may represent students particularly engaged with WP issues. Focus groups were limited to early programme stages and may not reflect experiences across the full trajectory of training. While peer facilitation is a strength is can also be considered a limitation as this may have shaped disclosure through shared identity, assumptions of common understanding,

Conclusion

Taken together, these findings support a shift away from deficit-based understandings of WP students and towards a structural and relational understanding of inequality within medical education. WP should be understood not as a single point of entry into medicine but as a longitudinal process that extends

throughout undergraduate education and into postgraduate training. While widening participation initiatives have been successful in changing who enters medicine, they have been less successful in changing the conditions under which medicine is experienced. Efforts to widen participation must therefore focus not only on access but also on ensuring that all students can participate fully, develop a sense of legitimacy and belonging, and thrive throughout their medical careers. Consistent with strengths-based approaches to WP, institutions should recognise and nurture the assets, experiences and motivations that WP students bring to the profession, rather than viewing them through a deficit lens.

Abbreviations

WP
Widening Participation
EBL
Enquiry Based Learning
IMD
Index Mass Deprivation

Declarations

Ethics approval and consent to participate

Ethical approval was obtained from the University of Plymouth Ethics Committee (4910). Participation was voluntary and did not affect academic progression.

Participants received PI contact details, and sessions were held during core hours to ensure access to support. Students received a participant information sheet prior to the focus group and informed consent was received to enable anonymised data to be shared. Confidentiality and peer dynamics were addressed prior to discussion.

Consent for publication

Not Applicable

Availability of data and materials

The datasets used and/or analysed during the current study are available from the corresponding author on reasonable request.

Competing interests

The authors declare that they have no competing interests

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Authors' contributions

Shehany Warnakulasuriya: Design, Acquisition, Analysis, Interpretation, Writing

Louise Venables: Acquisition, Analysis, Interpretation, Writing

Holly Stephenson: Analysis, Interpretation, Writing

Tasfia Khandaker: Conception, Design, Acquisition, Analysis, Interpretation, Writing

Gergo Pinter: Acquisition, Analysis, Interpretation

Kalum Warnakulasuriya: Conception, Design, Acquisition

Lauren Singer: Conception, Design, Acquisition, Analysis, Interpretation, Writing

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Figures

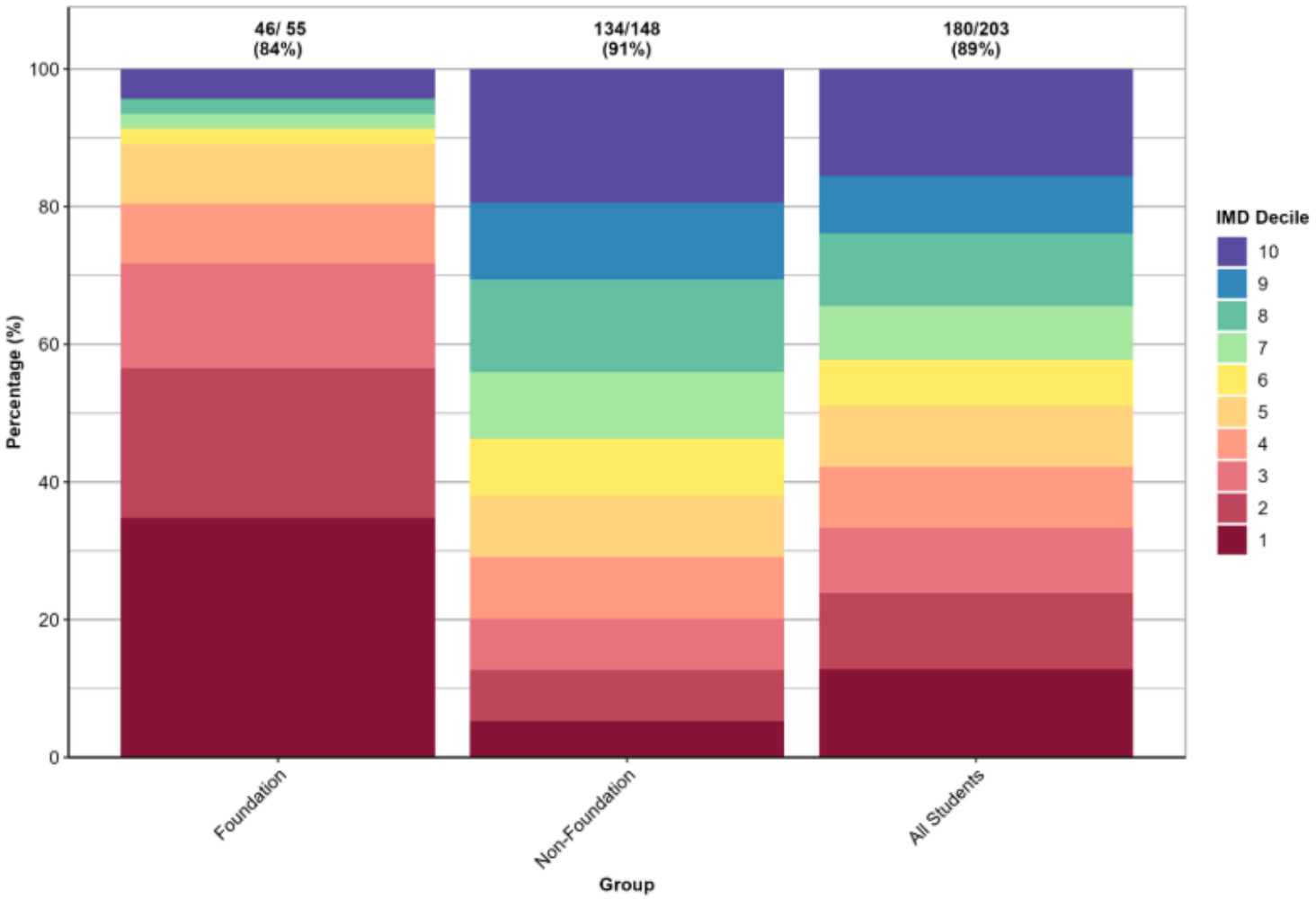


Figure 1

2025/2026 Index of Multiple Deprivation Data from Peninsula Medical School. Data from the 2025/2026 academic year show that students entering Year 1 via the Gateway programme were more commonly from lower IMD groups, whereas standard-entry students were more commonly from higher IMD groups. When these cohorts were combined, the resulting Year 1 intake demonstrated a more even distribution across IMD groups. The figure also highlights the differing socioeconomic profiles of students entering through these two routes, recognising that IMD represents one indicator of disadvantage rather than a direct measure of individual circumstances.

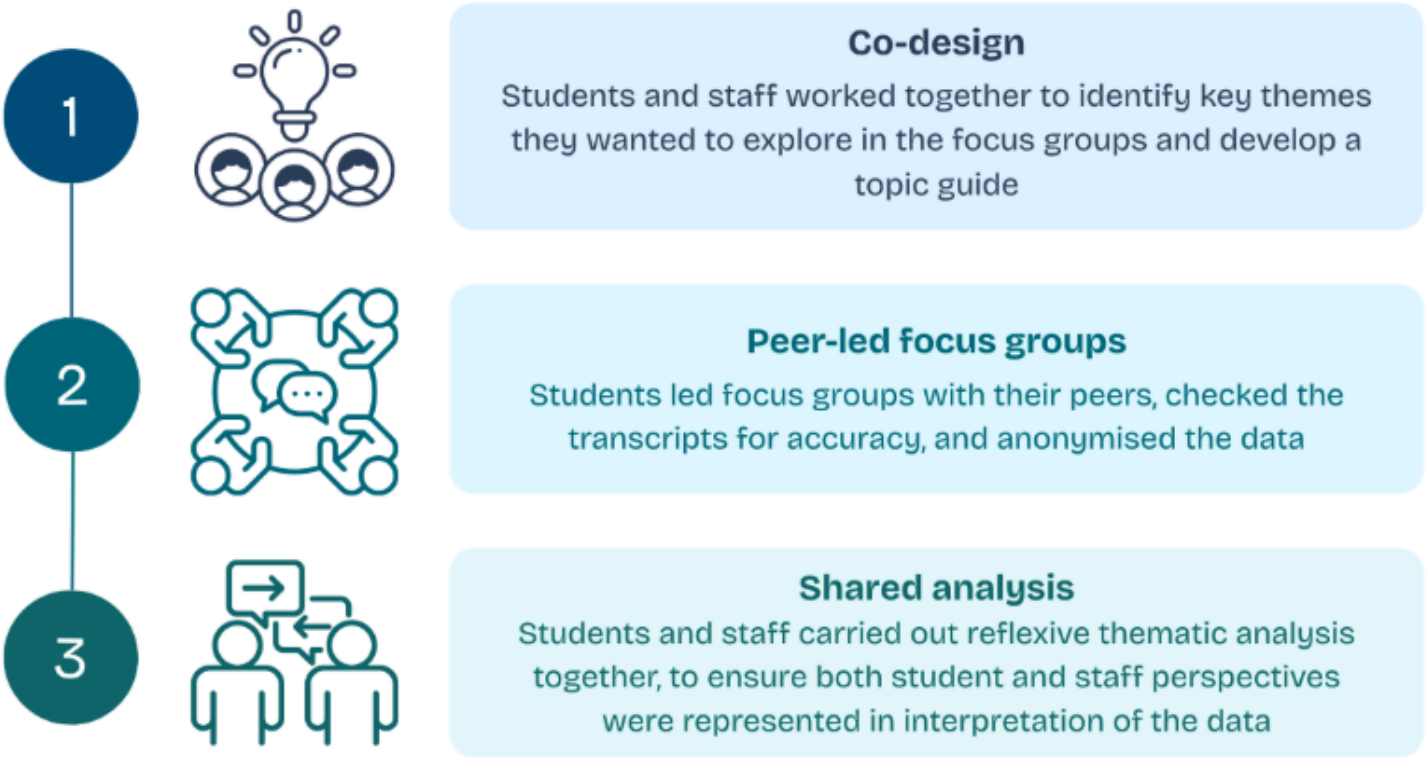


Figure 2

Diagram illustrating the co-created approach adopted in this study. Student collaboration occurred across three key stages of the project and was integral to its design and delivery. This co-creation enhanced the authenticity of both data collection and interpretation, contributing to the overall quality of the study.

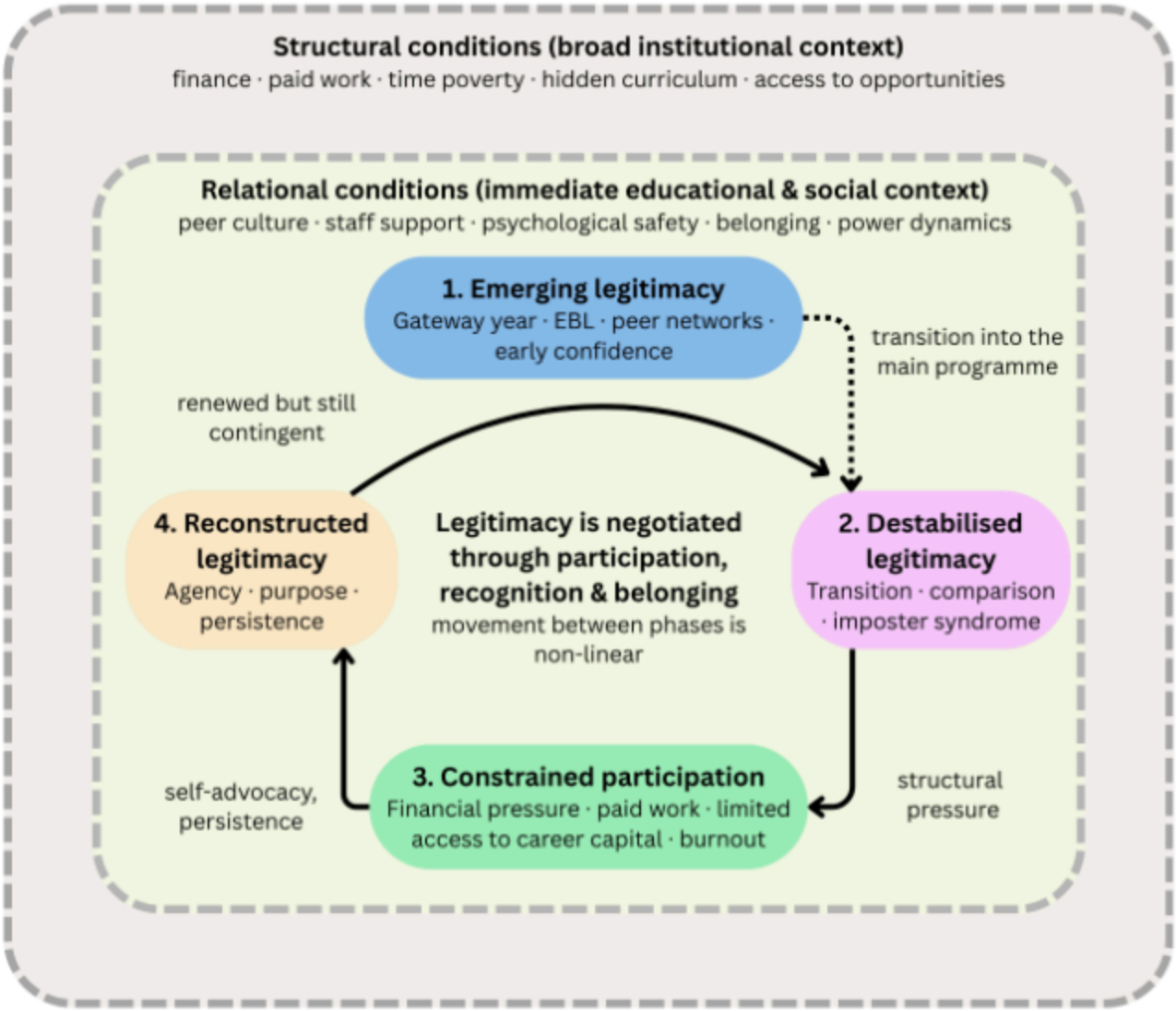


Figure 3

The Disrupted and Reconstructed Legitimacy Model: WP students' iterative journey through medical education. This model illustrates how WP students' legitimacy develops through early structured participation, is destabilised during transition into dominant medical school cultures, constrained by structural inequalities, and reconstructed through agency, persistence and purpose. Legitimacy is iterative and context-dependent, shaped by both relational and structural conditions.

Supplementary Files

This is a list of supplementary files associated with this preprint. Click to download.

- Appendix.docx