Taking context seriously: explaining widening access policy enactments in UK medical schools

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CONTEXT Since the 1970s, the UK medical student body has become increasingly diverse in terms of gender, ethnicity and age, but not in socio-economic background. This variance may be linked to large differences in how individual medical schools interpret and put into practice widening participation (WP) policy. However, attempts to theorise what happens when policy enters practice are neglected in medical education. We aimed to explore the dynamics of policy enactment to give a novel perspective on WP practices across UK medical schools.

METHODS We used a qualitative design employing individual telephone interviews to elicit views and concerns around WP from admissions deans and admissions staff within UK medical schools. We carried out interviews with representatives from 24 of 32 UK medical schools. Data coding and analysis were initially inductive, using framework analysis. After the themes emerged, we applied a deductive framework to group themes into four contextual dimensions of 'situation', 'professional', 'material' and 'external'.

RESULTS Our participants held different positions in relation to the interpreting and translating of WP policy, which were influenced by a number of contextual factors including: geographical locality and positioning of the medical school; the expectations of the university and other key stakeholders, and resources. The latter were subtle and referred to resources for medical selection processes rather than for WP *per se*. The data hinted that the political goal of WP and medical education's goal of producing the best doctors may conflict.

CONCLUSIONS This is the first study to explicitly explore WP policy enactment in medical education. Our analysis is useful for understanding differences in how WP policy is played out in local contexts, and for planning for future policy enactment and research. The messages identified will resonate internationally with all those engaged in efforts to widen participation in medical education.

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INTRODUCTION

One way to achieve progression within a society on the basis of merit rather than gender, race or class is through ensuring equality of opportunity in access to education.[1] Since the publication of *Learning Works* in 1997,[2] the term 'widening participation' has been adopted in the UK by central government, which has invested in widening participation (WP) or access (WA) to higher education by removing barriers and compensating for disadvantage.[3]

Although driven by policy and investment, the available data suggest that to date efforts to minimise the barriers against entry into professions such as medicine have had mixed success. Since the 1970s, the UK medical student body has become increasingly diverse in terms of gender, ethnicity and age. That progress, however, has not been mirrored by a similar change in the socio-economic background of medical students. Socio-economic background refers to an individual's or family's economic and social position in relation to others, based on income, education and occupation.[4] A recent synthesis of data from a number of sources (e.g. government, the General Medical Council [GMC], the British Medical Association [BMA], the Medical Schools Council [MSC], and individual medical schools) concluded: 'Medicine ... has a long way to go when it comes to making access fairer, diversifying its workforce and raising social mobility... Its success in recruiting more female doctors and doctors from black and minority ethnic backgrounds indicates that with the right level of intentionality the medical profession can also throw open its doors to a far broader social intake than it does at present.'[5]

It is clear that the impact of WP policy in medicine has differed by subgroup: the issue of WP in terms of socio-economic background, status or 'class' remains contentious in the UK. What is also clear and may help to explain this mixed success is that individual medical schools interpret and put into practice WP policy very differently. For example, publicly available information from medical schools admissions web pages and published research indicate that some UK medical schools approach WP by running extended medical programmes for students from certain backgrounds[6] and others accredit specific foundation-for-medicine programmes.[7] Some schools are explicit in their use of contextual data in selection decision making (this refers to assessing the achievement of a candidate in the context of the opportunities available to that candidate according to his or her education and socio-economic background), some focus on student-led mentoring of non-traditional applicants,[8] and others have introduced graduate-entry degree programmes.[9] (Evidencing the effectiveness of the various approaches to WP is beyond the remit of this paper, but see Cleland *et al.*[10] for a review within medical education and Gorard *et al.*[11] for a general review.)

Viewed through the lens of policy enactment, this diversity of approaches is unsurprising: 'Policies do not normally tell you what to do, they create circumstances in which the range of options available in deciding what to do are narrowed or changed, or particular goals or outcomes are set.'[12] Putting macro-level policy decisions into micro-level practice is a complex process through which to address an issue as required by legislation or other national drivers, but usually without explicit guidance on how to do so. Institutions, in this case medical schools, must interpret policy, drawing on their own culture, within the limitations and possibilities of their contexts, such as those defined by the resources available.[13] Thus, putting policy into practice is a process which involves the local interpretation of policy ideas by key actors, mediated by factors such as whether the policy is mandatory or recommended,[14] and how well the policy fits with the ethos of the institution.[15] This can result in policies being diluted[16] or superficially incorporated for accountability purposes rather than embraced for organisational change.[12,17] Policy is thus enacted rather than implemented within institutions.[18]

Although attempts to theorise what happens when policy enters practice have some history in education[19] and in health,[20] the locating of policy processes is neglected in medical education. This is perhaps surprising given the policy-driven nature of medical education in many countries, including the UK.[21,22] However, whereas medical schools are regulated at a national (UK-wide) level by the GMC, increasing devolution across the four UK countries (England, Wales, Northern Ireland and Scotland) has led to variations in approaches towards, and both policy and funding for WP, which results in a unique landscape for study.

The aim of this work was to investigate how WP policy is translated and interpreted for implementation at the level of the individual medical school, and to critically analyse these 'real world' perspectives and experiences using the novel approach of a contextual lens. Reflecting current policy and practice

focus, the aspect of WA under scrutiny in this study concerns the diversifying of the UK medical student body in terms of socio-economic background.

METHODS

Methodology

This study was underpinned by social constructionist epistemology and employed interpretivism as its theoretical perspective.[23]

Study design

We conducted a qualitative study using individual telephone interviews to elicit the views, experiences and concerns of admissions deans in relation to WP in medicine. We used a semi-structured interview schedule to ensure some consistency in interviewing and to elicit narratives of WP experiences.

Participants

After obtaining research ethics approval, we approached the admissions deans of all 32 UK medical schools. We obtained their e-mail and telephone contact details from medical school web pages (this information is publicly available). The first invitation was sent by e-mail and explained the purpose of the study and asked the recipient if he or she would consider taking part. Positive responses were followed up by an e-mail or telephone call to arrange a convenient time for the interview and request that the participant complete and return an attached consent form, either electronically or by surface mail. If we did not get a response within 2 weeks, an e-mail reminder was sent and copied to one other member of the admissions team whose details were available to us.

Data collection

MM conducted all interviews. Before starting, she reiterated the purpose of the study, invited questions and confirmed receipt of written consent. The interviews began with an exploration of selection procedures at each medical school and progressed to explore: the participant's understandings of WP; which WP activities the school participated in; how these were evaluated; the participant's views about the effectiveness of WP initiatives, and whether the participant could identify and explain barriers and facilitators to WP. The interview continued until the participant felt he or she had shared these experiences sufficiently. To end, we asked the participant for his or her views of the most important issues in ensuring that selection to medicine is fair to all applicants. We then closed the interview and thanked the individual for his or her participation.

Data analysis

All of the interviews were digitally audio-recorded and anonymised through the transcription process and then entered into qualitative data analysis software (Atlas-ti, Version 7.0; Scientific Software Development GmbH, Berlin, Germany) to facilitate multi-analyst coding of the data. We initially conducted a primary-level thematic framework analysis to determine content- and process-related themes (i.e. what participants said and how they said it, respectively).[24] This thematic analysis enabled us to identify key themes in our data around admissions deans' views, experiences and concerns around WP and to develop a coding framework to be used to code all data. Analysis progressed via regular team meetings and telephone discussions in which ongoing coding and comparisons were explored. Latterly, comparisons were made between codes and participants to explore differences and similarities in participants' experiences and views.

After the themes emerged, and following further team discussion, we extended beyond simple thematic analysis to critically analyse how government-dictated education policy was translated and interpreted for implementation at the level of the individual medical school using a contextual lens.[18] Specifically, we applied a deductive framework to group themes into four contextual dimensions: Situation (e.g. intake, setting); Professional (e.g. values, commitment); Material (e.g. budget, infrastructure), and External (e.g. performance pressures). Braun *et al.* argue that 'policies are enacted in material conditions, with varying resources, in relation to particular "problems". They are set against, and alongside, existing commitments, values and forms of experience.'[18] The use of the framework enabled us to consider objective conditions in relation to subjective 'interpretational' dynamics, and to explore the dynamics of context in the four dimensions, as well as their interrelationships because the dimensions are interconnected. For example, intake may be a situational dimension but it may in turn shape the Professional dimension in terms of values and experiences, as well as policy management.

The team comprised three medical educationalists (JAC, SN and MM) and one researcher (NK). All

team members had experience and training in qualitative research. One team member (SN) had been a medical school admissions dean previously. JAC, SN and MM regularly acted as selectors during the admissions process at their medical schools and held teaching roles in undergraduate and postgraduate medical education.

RESULTS

Admissions deans and key admissions staff from 28 of 32 graduating medical schools agreed to take part in the study. Of these, we interviewed representatives of 24 schools in the time available (September and October 2012). Admissions deans from all four UK countries (of the 32 schools, 25 were situated in England and seven were located across Scotland, Wales and Northern Ireland), representing undergraduate and graduate entry, rural and urban contexts, and all sizes (small, medium, large) of medical school were interviewed. To bring the research alive and to ensure anonymity, interviewees are referred to in this paper only as UG (if their role relates to a standard 5-year programme) or GEM (if their role relates to an accelerated or graduate-entry programme), or both.

The mean length of interview was 53 minutes and 30 seconds (range: 25–78 minutes), and the total data represented approximately 23 hours of interview time.

Situation

'Situation' refers to historical context (e.g. age and reputation of the university) and setting or location (e.g. large urban area, smaller urban area, specific location within the UK). Medical schools are situated across the four UK countries in both affluent and more socially mixed areas, and in both ethnically diverse and relatively ethnically homogeneous areas. They may be seen as academically and socially elite in relation to other medical schools or as more embracing of students from wider backgrounds.

Our data suggested that the locality of the medical school was very relevant to WP policy enactment. For example, an interviewee from a medical school in an area of socio-economic deprivation said:

> 'Yeah, the University of Xxx has a wide tradition of widening access. It's probably one of the top two in the country, I think, in England in terms of WP. I mean, I'm not quite sure but I, I do think we have got a background in it and I think it's probably because of the location, unfortunately [laughs]. Er, you know, there's quite a lot of disadvantage in the Xxx.'Interviewee 3 (UG and GEM)

> 'But we do work very actively to try to encourage widening participation. Um, it… you know, Xxx is a fairly down-to-earth sort of place and, and we are keen to, to, um, you know, widen the net if we can.'Interviewee 11 (UG)

Locality was also important in terms of which societal groups were specifically targeted in WP activities. For example, medical schools in large cities tended to focus their WP activities on pupil groups and schools that were ethnically diverse (as well as of lower income). By contrast, those schools situated in less urban locations focused on drawing in local applicants who may have been mostly White British (and of lower income), but reflected the make-up of the regional population:

> 'The reason the new medical schools were set up … was to increase the supply of doctors for the local health care economy, so part of the idea is, if we can recruit students from the local area, they're more likely to want to work here in future.'Interviewee 17 (GEM)

The ultimate goal of WP activities was always the same: to attract medical students who would go on to become doctors 'as representative as possible of the society they serve in order to provide the best possible care'.[25,26] However, who these future doctors may be differs, to some extent, among medical schools. Locality and history intersect in that neighbourhoods change over time and thus although the physical locality of an existing medical school may not change, there may be more fluidity in the population of the area from which the medical school has traditionally attracted students. However, change at this level is slow and thus government policy to open new medical schools or streamed intakes in (mostly socially deprived) geographical areas in which a shortage of health care professionals is predicted is relevant because location and intake are, in most cases, interrelated. Medical schools with high-esteem international reputations tended not to focus as much on local WP activities, perhaps because they drew applications from a wide pool of UK students or because there were no shortages of doctors in their localities. For these medical schools, there seemed to be a particular dilemma

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between the maintenance of performance standards, and hence reputation, and WP. We will return to this theme later.

Another relevant aspect of context referred to the selection process of the medical school. Some participants struggled with their awareness that many of the processes traditionally used for selection for medicine do not promote WP and wanted to be fair, but at the same time were required to use a 'workable' selection process.[10] This dilemma was often addressed by the use of contextual data:

> '[If WP activity] translates into any applications from those schools, Xxx… and now me… always did the marking of those ones, and also would give them additional marks on their school just to try and kind of get over the fact that they don't have all the advantages of the private schools.'Interviewee 1 (UG)

However, the data indicated that different medical schools used different contextual markers and used these diverse markers in different ways. It was also often unclear just how contextual data were used in the selection process. This seemed to intersect with the dimension of Professional. There are issues here about not only lack of transparency, but also consistency both within and between medical schools in any use of contextual data. All of these are disadvantageous for the WP candidate.

Professional

This theme refers to the interviewee's values, commitment and experiences of WP policy within his or her medical school. This is not about leadership *per se*, but about the individual's outlook and attitudes and how these might influence how WP policy is enacted. In other words, this contextual dimension centres on the position of the individual as an actor in the process of playing out WP. It encompasses personal emotions and beliefs related to WP, as well as attitudes towards the usefulness of medical school WP activities.

The majority of our interviewees were committed to the principle of WP and regarded engagement with it as a core part of their role. However, they discussed the limits of what medical schools could do to address societal inequalities and were realistic about what their WP activities were able to do to address issues beyond the control of the medical school:

> 'Um, [sighs] I, I think one of the things that I, I do say a lot is that it's all well [and] good us doing what we do and other med[ical] schools do what they do, but, um, we do need help from schools in giving good advice and guidance and making people, making students believe that they've got the ability to do well.'Interviewee 5 (UG)

> 'We can only select from those who apply…'Interviewee 22 (GEM)

> 'The government is trying to tackle the issue of inequalities in education at university level, when it should be tackling it at school level, and that actually, the effort should be made to make sure that people who come from certain backgrounds are not disadvantaged academically, rather than forcing universities to take people who haven't demonstrated the level of competence that other people have, because there's maybe two reasons for not gaining that level of competence. Either they haven't had the opportunity or they're not that competent. They would be better served by a higher quality education system between the ages of 12 and 18 than by being given some sort of artificial leg-up at age 18.'Interviewee 23 (UG and GEM)

This suggests a sense of injustice that the onus is on medical schools to address issues within the compulsory (age 5–16 years) education system. Moreover, participants were well aware that the traditional methods of selection for medical school (academic attainment) were insufficient and needed to be combined with other selection methods.[10] However, academic attainment is linked to performance (at medical school at least[27]), and there was some anxiety about the impact on reputation and standards of lowering entry standards for some groups (as one way of enabling those with lower school attainment to enter medical school).

Associated with this was a certain cynicism about the political drivers behind WP policy:

> 'The Xxx medical schools all participate in this thing called XXX. I can't remember what it stands for now, which is the latest bribe-cum-handout by the xxx government to try and get the universities to recruit differently.'Interviewee 4 (UG)

> 'Er, are we really trying to select on the basis that we want to make the, the composition of medical schools as close to the cross-section of society as

possible; is that a reasonable aim? Is that a political decision; if it is then is that [a] university's role to go along with that?'Interviewee 20 (UG)

This is associated with the second rationale for WP to medicine in the UK, which is to improve the provision of health care by ensuring doctors are as representative as possible of the society they serve in order to provide the best possible care to the UK population.[25] Although most of our participants did not seem to contest the need to play out WP policies locally, many were unable to identify evidence that these activities led to measurable change. There was little emphasis on whether or not WP activities were successful; rather, participants focused on what was done (not on how well it was done). Few medical schools were evaluating WP activities, although this may have at least partially reflected limitations in resources:

'And I think more so we're getting those, sort of, figures but I, I don't really know how it, it actually... I think we're doing very similar outreach work considering the same things as other institutions, but whether that actually affects the numbers on the programme, I'm not sure.'Interviewee 3 (UG and GEM)

Material

This theme refers to practicalities such as budget, staffing and infrastructure, which can have a considerable impact on policy enactment on the ground. Views and experiences of funding for WP varied across our participants. Some were quite positive: for example, our participants talked about the availability of university-wide resources:

'The other reason why we've gone with the university scheme is that they already have all the links into the schools, and they've got those relationships already built up, and they've got the ambassador training already set up, and they can make sure that our students are safe, and they can also help us with the, you know, recording of data from the business that they've undertaken, so it's really a very big win win for us, because half the job's done, and they've been very enthusiastic and supportive of the medical school putting a lot more effort into WP, and getting the students more involved than they have been in the past.'Interviewee 17 (GEM)

'So there's a team of, of people who work, um, on that for the central university and then we tap in or they tap into us in terms of what activities have you got on, what activities have we got and can we help each other with?'Interviewee 22 (GEM)

Others spoke about national WP initiatives that came with funding. There was, however, a belief that WP resources differed significantly across medical schools:

'I know a lot of people do a lot more, and put an awful lot more money into it, but it's about resource. You know, it's not about enthusiasm, it's about resource. And I think that's the biggest, biggest problem, is trying to find the money. But not just one-off money, I'm talking about ongoing academic time, I think that's the biggest challenge.'Interviewee 25 (UG)

On the whole, the data did appear to indicate that some medical schools had more resources for WP than others. However, this clearly intersected with the situation of the school in terms of its locality, and its historical and external contexts. For example, it seemed that a number of years ago, when WP was high on the political agenda, some medical schools decided to commit to WP to meet the needs of the local population and hence applied for additional places (numbers entering medical school in the UK are centrally controlled) and associated funding to set up extended programmes or to support foundation years. These have had reputational implications for those schools (they are seen as supporting WP), whereas other schools, which did not take this initiative, appear to struggle on with the resources available to them. Reflecting this to some extent, WP was seen as 'a ton of work' (Interviewee 26, UG) that requires significant staffing.

It was clear from the data that, generally, medical schools tended to focus their available WP resources on developing and rolling out WP activities, but neglected to evaluate the impact of these activities. Our participants talked, mostly enthusiastically, about the WP activities of their schools, but were unable to tell us if these had actually had any impact on their student populations. This finding intersects with the theme of external context by indicating that unless there is pressure on medical schools to report outcomes, they will not do so. Our data suggested this was at least in part the result of the sheer pressures imposed by other mandatory reporting.

Our participants also talked about resources to support the development of selection systems as these were seen as being closely tied to WP (in terms of some selection procedures being 'fairer' than others). The resources available for selection seemed to be limiting factors in terms of facilitating change:

> 'It's got to be doable. I think that's the other thing... We've got to tailor it into what's possible. You could make it a lot more, but it would be the resourcing it. So we've got to do what we can do within... within our limits.'(Interviewee 1, UG) [speaking in relation to changing from traditional admissions interviews to a mini-multiple interview format]

There was little in terms of robust evaluation of selection processes in terms of their impact on WP:

> 'We're in the category that, sort of, use UKCAT, hopefully, in a way which we... we hope is most beneficial to widening participation.'Interviewee 8 (UG)

External

The last dimension is that of external context. Medical schools do not exist in a vacuum. There are pressures and expectations from a range of key stakeholders including, in no particular order, the regulator (the GMC), applicants and their parents, the government, the wider university with its focus on income, league table positions and ratings, health service partners, and the general public.

Some institutions appeared to be more committed to WP than others. Some schools were seen as paying lip service to the principles of WP policy usually because WP did not fit with the culture, ethos or aspirations of the medical school, whereas for others WP was very much part of wider university culture, as demonstrated by these two contrasting comments:

> 'I get a sense that the other one, er, was doing it more out of needing to, er, to tick a box that says they have a certain proportion of students who, um, er, need... need to enter the university and the... and the medical school, er, with a particular profile...'Interviewee 8 (UG)

> 'I think the whole widening participation agenda here is handled very much as a university-wide and college-wide issue. So it's not just about medicine, it's about everything.'Interviewee 9 (UG and GEM)

It seemed from the data that medical schools that aspired to be elite were more likely to superficially map WP onto their selection practices. Why was this? There seemed to be fears that firstly students from WP backgrounds would struggle academically, and hence bring disrepute to the medical school by underachieving or leaving mid-course. (The data indicated that only in medical schools that ran specific extended programmes or separate WP schemes did successful applicants from WP backgrounds receive any ongoing support. Otherwise these students were usually left to 'sink or swim'. This may have been linked to lack of resources to some extent, but the data suggested that medical school culture was the more important factor.[28]) Moreover, UK medical schools are funded per student and numbers are capped, so there is a financial loss to the school if a student drops out:

> 'And given if a student drops out or has to leave because they failed to meet the mark and the university loses out financially... You're in a position, you're put in a position to recruit the people that are most likely to succeed rather than having 20% of your students where you expect that there's a higher dropout rate.'Interviewee 7 (UG)

In addition, by accepting a proportion of WP students, a school might be perceived as depriving well-qualified 'traditional' students of a place to study medicine, and this might attract negative publicity for a medical school:

> 'There was a bit of a political outrage about it all to start with which we had to go with as well... Some of the vitriolic haranguing was quite horrendous at the time.'Interviewee 14 (UG and GEM) [talking about extra places for WP students]

> 'XX doesn't sound very many, but on the other hand, the point has been made to me, for every one of these students who gets three Cs, you're denying a place to somebody else who got maybe, two As and a B and just missed out, who happened to go to a slightly better school, perhaps, in a slightly better part of Xxx. You know, I've actually had outraged members of staff saying this is social engineering, which it is, actually.'Interviewee 23 (UG and GEM)

Thus, a school might be subject to the 'double whammy' of risking its reputation by selecting WP entrants who then fail to manage the demands of studying medicine, and infuriating parents who had the means to educate their children well with the goal of achieving entry to study medicine or another profession. This comment also links to the earlier point made about the injustice of placing the onus to address issues associated with the compulsory (school) education system on medical schools.

There seems to be a mismatch between the political goals of WP in terms of its addressing of under-representation and the medical school's goals of producing good doctors:

> 'But what is often perceived, and reality might be a little different, is the political goal is something different, and it's... it's more people with, who come from sort of, you know, socio... uh, poorer, more deprived socio-economic groups, in terms of their families, or their communities, or their own origin, and that... and that somehow, success will be defined when you have greater numbers from those backgrounds. But actually, success shouldn't be defined quite that way. It should be defined by, are we identifying getting people who then go on to be excellent doctors, rather than solely numbers by some sort of, you know, uh, social stratification.'Interviewee 2 (GEM)

DISCUSSION

To the best of our knowledge, this is the first study to explicitly explore the enactment of WP policy in medical education. We used Braun and colleagues' heuristic framework[18] to illustrate how context is important in asking questions about the circumstances of WP policy enactment in medical education. We identified that a number of contextual dimensions – Situation, Professional, Material and External – interact to influence the enactment of WP policy in UK medical schools. We have teased out how these dimensions individually have influence, but the bigger picture is derived from how these dimensions interrelate. Firstly, some schools appeared to be less committed to the principles of WP policy than others. The reasons for this refer to how WP fits – or does not fit – with the culture, ethos and aspirations of the medical school. For some interviewees, this was clearly linked to fears that WP students would do badly and would thus threaten the school's funding and reputation. For others, the reasons were less tangible and seemed to be more strongly linked to the fact that WP was not a university priority. Having fair and equitable selection processes was seen as critical to WP, but local context, attitudes and resources influenced these processes, and the use of different entry criteria for WP applicants was perceived as problematic on a number of levels. The attitude towards WP of the person in the role of admissions dean or lead seemed critical to how WP policy was enacted. Financial resources were not an obvious issue, but how they were used was of interest: funding was mostly directed towards unevaluated outreach activities. This links to external drivers in that the data suggested that how medical schools are required to report on their WP activities exerts a strong influence on what they do.

We will discuss two aspects of the data in a little more detail to illustrate their importance in the process of policy enactment. Firstly, we examine the role of the admissions dean. Although policy mandates tend to consider all those in the process as equal and as working on and with policy in the same ways,[29] our data suggest this is not the case. Rather our participants had different positions within the Professional dimension as 'actors' in relation to interpreting and translating[30,31] WP policy. These ranged from positions of relative indifference to those of full engagement. The interviewee's position was critical to making WP policies happen in the medical school (in terms of implementing the use of selection methods considered to facilitate WP). In this way, our participants were 'both receivers and agents' of (WP) policy.[30] Furthermore, as agents, admissions deans also have a dual role.[31] Firstly, they must account, report and monitor WP policy implementation as required by the regulator (which intersects with the dimension of External factors). Secondly, they must interpret and explain policy, decide and then announce what is to be done, and what can and cannot be done (which intersects with the dimension of Material factors). It is in the second role that the individual (Professional dimension) influences local policy enactment.

Further, in terms of the Material dimension, resources for WP *per se* did not seem a particularly limiting factor in terms of enactment (possibly due to government grants to institutions for WP activities, an External factor). There were more subtle material influences at play, however, in terms of resources for medical selection processes. Medical schools wishing to change from traditional selection

methods, such as individual interviews, to 'fairer' methods, such as multiple mini-interviews (MMIs), were limited by local resources. (Interestingly, however, research indicates that an MMI can be delivered with the same level of resources afforded to typical traditional interviews.[32,33])

Given that individual medical schools have been left to proceed with WP in their own way(s), it is hardly surprising that there are differences in terms of institutional and personal engagement, and in how WP policy is interpreted and worked into current practices. We propose that it would be fruitful to draw on lessons from other disciplines to help put WP policy into practice in a more coherent and measurable way. In health, for example, there are parallels to WP in terms of policy concerns and government investment in reducing health inequalities, and frustration about lack of evidence about the impact on health outcomes of these policies and investments (e.g.[34,35]). In response, a large health planning literature has emerged over the last 20 years and has developed and championed a number of frameworks intended to support and enhance practice related to the developing and implementing of policy-driven interventions (e.g.[36]). These may be transferable to, or modifiable for, medical education. Albeit that assessing any policy failure is inherently difficult in terms of linking outcomes to causal antecedents, we suggest that any WP policy will be more likely to achieve its goals and be effective if policy implementation is rigorously planned and evaluated in terms of both process and outcome.

In the field of WP research, there is a preponderance of single case studies, very limited use of relevant theory to underpin analysis and a paucity of attempts to provide an explicit, explanatory focus.[10] By contrast, the present paper reports a national perspective and a theory-driven data analysis. Data collection may have been enhanced if we had used group interviews to enable participant interaction, but individual interviews are superior in allowing each participant time to share a greater amount of information.[37] Moreover, individual telephone interviews were the only practical means of collecting data from a large number of high-level individuals located across the UK. It would have been informative to have included the type of university (e.g. ancient or modern; performance as assessed by world ranking) as a stratifying factor to find out if there were any potential differences in policy enactment based on this factor. However, UK medical education is relatively small (32 graduating medical schools at the time of the study) and this would have jeopardised respondent and institution anonymity. However, patterns emerging from the data indicate diversity across medical schools and are worthy of further in-depth investigation. We interviewed admissions deans only, but exploring the views of applicants, parents and students, and those who provide advice and support to people wishing to apply to medical school, such as teachers, might have provided other perspectives on the issues identified and explored in this study. We did not explore the relationship between WP and what makes a 'good' doctor as our focus was on the enactment of existing policy: all UK medical schools must produce 'good' doctors as per the guidance set out in the GMC document *Good Medical Practice*.[22] We focused on WP in terms of socio-economic background only as this is the main current UK focus. However, the present work might have been strengthened if we had also studied the interactions between socio-economic class and other potential dimensions of disadvantage, such as gender and ethnicity.[38] We focused on policy enactment in one context (i.e. one country), but, given the breadth of the sample, the messages identified will resonate internationally with all of those engaged in efforts to widen medical school participation.

We did not aim in this paper to identify which dimension was most important; neither did we aim to suggest how best to implement WP policy. Rather, we wished to illustrate, through the use of qualitative data obtained from representatives of a large number of medical schools, that how WP policy processes are played out varies on the basis of contextual dimensions. Such an analysis provides a more nuanced account of the processes of WP within medical schools than has been available to date. This facilitates better understanding of the present situation and hence enables informed decision making on what might be open to change and how best to direct change. In conclusion, WP policy is played out differently in local contexts depending on a combination of factors, including resources and 'fit' with the ethos of the institution. This may disadvantage applicants, particularly those from WP backgrounds who will be less likely to be aware of contextual nuances than more traditional medical school applicants. We also identified a mismatch between the goals of WP policy (to achieve a certain social breakdown of medical students and hence doctors) and those of medical schools (to produce excellent doctors) which seemed to translate at times to a situation in which WP was less about reaching out to those who have the ability to

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succeed at medical school and more about playing a political game of numbers. This state of affairs must be addressed.

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