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Interview: Robbie Duschinsky, AE at MH, and Jane Macnaughton 28th March 2018

Jane Macnaughton has been a leader in the field of health humanities in Britain, from her position over 18 years as Co-Director of the Centre for Medical Humanities at Durham University. During this time, she has continued work as a clinician.

She was part of the core group that set up the Association for Medical Humanities in 2000 with support from the Nuffield Trust, and served as inaugural Secretary. She edited the journal Medical Humanities from 2002-2008. More recently, she played a key role in the establishment of the Northern Network for Medical Humanities Research in 2013. Between 2015 and 2017 she was Dean of Undergraduate Medicine at Durham.

Jane's research has focused on the relationship between doctor and patient, as well as the patient's embodied experience of symptoms. Aligned with her clinical work she has written extensively about people's bodily experience before, during and after the clinical encounter. Key works include her 2007 book "Bioethics and the humanities: Attitudes and perceptions", and her 2011 article "Medical humanities' challenge to medicine". With Havi Carel (Bristol), she currently holds a Senior Investigator Award from the Wellcome Trust for her project, the Life of Breath.

I had the pleasure of interviewing Jane on the 18th March, 2018. I was interested in issues of community-building, leadership and management in the medical humanities, topics that have seen surprisingly little public discussion but which are important for the survival and thriving of the field.

The interview begins by exploring the emergence and growth of the Centre for Medical Humanities at Durham, before then addressing how Jane has handled some of the challenges associated with leadership and management in the medical humanities. This includes dilemmas associated with community-building, the demands of building momentum whilst continuing to be responsive and listen, and the care required in mentoring early career researchers without job security, and issues of legitimacy and synergy in bridging humanities and clinical work.

Jane's career spans a fascinating period of change and development, and the interview offers a particular and personal journey through major changes in the intellectual, ideological, and funding bases of the medical humanities in Britain.

Robbie Duschinsky (RD) – The Centre for Medical Humanities at Durham has been an important institution for research in the medical humanities within Britain. To me, it felt like the Centre had an important role in shaping the tone and scope of work in the medical humanities at the point I was entering the field six or seven years ago, including serving as a touchstone and a model. As a starting point for this interview, I would be very interested to hear about how it came about that, in 2000, the Centre for Medical Humanities at Durham got founded. What was it aiming to achieve?

> Jane Macnaughton (RJM) – Sir Kenneth Calman had become the vice chancellor at Durham University. He was very interested in this whole field and invited me to apply for a post he was creating, which was to start a Centre at Durham. I had known Ken at Glasgow University: he was postgraduate Dean in Medicine at that time when I was there as Lecturer in General Practice, and we'd set up some set up some voluntary classes reading bits of literature for medical students, which had been very successful. Out of this, and

during his time as Chief Medical Officer, Ken had got in touch with the Nuffield Trust and had persuaded them to put some money behind the field. Two conferences were set up. They were called the Windsor Conferences, held at Cumberland Lodge at Windsor in March 1998 and September 1999, and were an attempt to bring together the disparate elements of the field. One element was medical humanities, which was identified as particularly related to medical education. The second element was the arts therapies, and the third element was arts in community health and development. So three distinctive fields. And out of the two conferences came a resolution for two things: one that there would be a Centre set up, an academic centre for medical humanities or related ideas, and then the other would be that there would be a network set up for artists working in the field of health. So out of that came the Centre at Durham, supported by some funding from the Nuffield Trust, and the National Network for Arts and Health (NNAH) led by Lara Dose.

We initially called ourselves the Centre for Arts and Humanities in Health and Medicine, because we were trying to be comprehensive and bring in some of the arts and health work, which was quite strong in Durham, Newcastle and Gateshead at that particular time. Before I came to Durham I remember setting out a vision for what the structure would look like in an attempt to support the development of these different fields, the arts in health field, the educational field and the beginnings of thinking about how research in medical humanities might influence the evidence base and what happened in clinical care.

RD – It sounds like the initial components and ambitions of medical humanities at Durham twenty years ago differ in some ways from the medical humanities that I recognise now in the work of the Centre and of the field more generally. In particular, it sounds like medical humanities was much closer to medical education, and had a somewhat different relationship with arts health.

RJM – You're quite right. The initial components were very different and so were the goals. My dear colleague who died a couple of years ago, Mike White, had a very strong influence. His work grew out of a social justice idea, thinking about the importance of the arts in health: the sense that the arts were important for individuals and also for community regeneration. And at this time Gateshead had become a big focus for the ways

in which the arts were helping to regenerate the community, so we had the Sage Gateshead (in an iconic building designed by Norman Foster), the Baltic Art Gallery had just been opened, housed in another iconic, repurposed building by the Tyne, and various other things were beginning to happen. Mike had been closely involved in the commissioning of Antony Gormley's Angel of the North sculpture. So there was a real focus of attention on that and an expectation that the Centre at Durham would start to get involved in some of that work. But at the same time at Durham, for the first time since the '60s, Durham was taking on medical education again. A number of new medical schools established at that time, most of them collaborative across two institutions. Ours was set up so that our students would finish in Newcastle, and we had a two-year programme. So I was appointed as the Director of the Centre but part of the remit of the role was to help develop the new medical curriculum. So there were definitely at the outset these two different fields, medical humanities (understood largely as directed a medical education, and arts in community health and development. We were not engaged in the third area addressed by the Nuffieild conferences, that of the arts therapies. . And when I came in my interest was through the educational route, my experience and my background had been through that, and I'd done a lot of work on what were called at that time special study modules, now called student selected choices (part of the GMC's review of medical education through its publication Tomorrow's Doctors), giving the opportunity for medical students to study subjects outside the core curriculum. So, in developing the curriculum at Durham, we made use of philosophy, literary studies, and other humanities approaches to get them to think about different perspectives.

I could sense there was a hunger amongst some of the medical students, a proportion of the medical students, to have this kind of wider learning, and one of the reasons why I got into this field in the first place was my frustration with medical education, my sense that here we are sitting in great institutions of learning as medical students, and yet we're being bombarded with facts and we're not being encouraged to think. So in a sense my ambition, ultimately, was less about 'humanising' and more about giving a wider educational experience. It was more of an opening minds, and one would hope that by doing that you would make people more aware of the context of people's lives.

But when we got into developing the curriculum, we were constrained by particular elements of that curriculum, by the rules laid down by the GMC. So although we did use drama, we used some materials from alternative sources that wouldn't normally be used, novels, poems, some plays in fact, I had a sense of the limitations. It struck me that we were always only going to get buy in from no more than about 30% of the student population, and I was also becoming aware that this was related to a culture within medicine and medical practice that had very strong views about the hierarchy of the evidence base that needed to be generated. So I was beginning to get inklings that we were bashing against a closed door by going about medical humanities in this way, and that when the students came out of their training any little seeds we had planted in relation to medical humanities during their education weren't going to grow or change anything in that culture. So there was the beginnings of an inkling something would have to change in the wider culture of medicine.

And in relation to the arts in health the Centre began to develop two lines, I was working more on the medical education side, and then my colleage Mike White was working more on the arts in health. But of course you're responsive to the needs of what's out there and what's happening in the community within which you're working. In our case, that was the medical school and the Gateshead arts regeneration. But you're also aware of where there might be relevant funding. The only funding of any reasonable scale at that point was actually within the context of design and decoration of new hospital builds. At that time the organisation called NHS Estates providing grants to people who were researching the impact of particular hospital design and decoration on the patient and NHS staff population. So Mike and I began to work in that way, and we did actually look at the responses of medical students in these contexts, so we had a bit of a crossover. Indeed, the initial funding of the Centre was entirely through some of that design and decoration of new-build hospitals, big PFI (Private Finance Initiative) builds, that were happening at the end of the '90s and early 2000s. So we did a lot of work on that.

It was only as we approached 2008, so eight years after the Centre began really, that the Wellcome Trust started to shift their perspective away from entirely focusing on funding just the history of medicine into a wider conception of what medical humanities might look like. And I think – others might have different views – partly in order to stimulate that diversity they had a competition for Strategic Awards in Medical Humanities, one of which we received in 2008. Two awards were made: to ourselves and to Kings College London. There were a few factors that helped us put in a credible application. One was that we had attracted Martyn Evans to join us at Durham. Martyn had been at Swansea, and had been responsible for setting up the first Masters course in medical humanities. I had got to know Martyn as external examiner on his Masters. Through our discussions it became apparent that we both felt that it was important that if we've got this new field we needed to make it visible through academic structures. So what academic structures do we need? We needed a journal, and we needed an academic association that runs annual conferences to create a community around this field in the UK, which didn't exist yet. So Martyn did most of the work in persuading BMJ to take on the journal, which became a twice-a-year thing, and he and I edited it in the early years. And we also set up the Association for Medical Humanities.

So we were both responsible for these structures, and then we were working to show what sort of identity this Centre at Durham had. I think we were very fortunate in the cross-disciplinary thinking fostered at Durham at that time, and we had the sense that there was a academic field developing. We'd created structures that would enable others to feel like it was an academic field that was emerging. And there was somewhere for people to report what they wanted to talk about, the journal. But the big thing that was missing, I think, was just enough bums on seats to get the thing really moving, enough people who were able to focus their attention entirely on this rather than the rest of us who had lots of other conventional academic jobs to do. This was what was so wonderful about the Wellcome stepping forward with funding.

RD – In that regard, was the medical humanities that got set up by Martyn's Masters course and

the medical humanities that was given strategic awards in 2008 the same thing? Or had medical humanities changed in that period?

RJM – What the Masters did was it enabled the students to range across a number of disciplinary areas. There was history there, there was philosophy there, there was sociology there. It was a kind of 360 degree sense of medical practice from these kind of non-scientific perspectives. I think one of the things that perhaps was missing from that Masters which came into our thinking in the Centre, was interdisciplinary synthesis of our ideas. But at the stage when we started to develop the Strategic Award we weren't really doing that. In the process of developing the bid there were four of us, myself, Martyn Evans, Corinne Saunders and Sarah Atkinson – and Corinne Saunders and Sarah Atkinson are still very much involved in the current Centre. The process of developing the bid was a really exciting thing to do because that was when I think we really did get together to talk, across disciplines, to try to get work out what was it about this field really was perhaps going to be important. What we came up with through a discussion aross our different disciplinary fields (Martyn philosophy, me Medicine and a background in philosophy and history, Corinne, literary and cultural history, Sarah, health geography) was a project with an overall heading of 'Medicine and Human Flourishing'. The idea was that this strategic award would enable us to investigate in a truly interdisciplinary way what contributes to human flourishing, not just wellbeing. The rejection of a more 'health-related' concept such as wellbeing would enable us to interrogate the assumption that health might be a necessary condition of flourishing. That was the first time I think when we began to see this process of actually talking across our different perspectives, or different experiences or different intellectual groundings, as itself important. We felt the process that we'd started in terms of putting in that bid was one that we wanted to continue with the new Centre, if we were lucky enough to succeed. And I think one of the things that helped us hugely was we did spend a lot of time together, the four of us, so when it came to the interview it was absolutely clear that we'd worked together very closely, and that we could work together.

RD – Looking at it from the outside it seems to me that already by 2008 there was a slightly changed relationship with medical education. Was that something that felt like it was occurring from the inside as well?

RJM – I think it definitely was. Martyn Evans was slightly involved in medical education, but I was really the only one who was in particular. And the other two weren't. Corinne Saunders is in English Studies, Sarah Atkinson is in Geography. I've learned a lot from Sarah's perspective as a social scientist because she kept bringing me back to the fact that what we were doing was not all about that clinical context since most of health happens outside of that. That was very valuable because I think when you've been brought up through a clinical context you tend to think that that's the most powerful influence on health, when it is absolutely clear that's not the case. I began to feel my two lives separating, I think quite significantly. There was one life as an educator; our medicine programme was based at the Stockton campus about twenty miles south. And another life as a researcher at Durham, which represented something other.

And so things began to diverge, and I think that helped make me think: 'OK, well what's this Centre about then?' We're not really about developing medical education, we're much more about something else, and that something else hadn't really become clear in my head at that point. But when we got the Strategic Award we then appointed three new members of staff. One of those was Angela Woods, one of them was initially Bethan Evans, a health geographer interested in fat studies, and then Felicity Callard, and another was a member of staff who did not work out as well. But that gave us two people who were entirely focused on developing thinking. Now you'll see that neither is involved in medical education, and so the idea in appointing them was to find exciting thinkers who are instinctively working across disciplines, and who have this sense of wanting to change how health is thought about in radical ways. They have the clear ability to show, through their work, that the evidence base that influences healthcare needs to take into account a wider range of knowledges and of methodological approaches.

RD – From when you were hired as a lecturer at Durham, I'd be interested to hear a little bit about this issue of community-making, and how community-making in the medical humanities - what particular qualities, opportunities or challenges this has.

RJM – Well there's a macro and a micro issue, and maybe also a personal one. I suppose the macro issue is about the field as a national or international field. There's such a lot of disagreement about what constitutes it. So we've got all this interesting terminology, and people have written reams about trying to define it. We've got 'health humanities', we've got 'medical humanities', we've got 'arts and health', and people trying to make distinctions between them, trying also to think about the relationship with medical education. There's this continual sense of trying to define the field, and even within the UK there is a fracturing of what the field is about.

The micro issue is the love and extra effort that's required when you are not supported by disciplinary infrastructures. Even in Glasgow when I started to set up the modules that we taught to medical students there had to be a sense of openness, and a willingness to do more than your job specification, out of love, I suppose. And so when I moved to Durham, again that same sense that, in order to build it, one had to go the extra mile. So that people would come together, even though that meant working a lot harder, meeting up at difficult times. And that's been my experience I think, of creating and building the Centre. Let me give an example that struck me most forcibly in the first couple of years after coming to Durham. At the time I arrived in Durham, Mike White was working for Gateshead Council in a job that was a full-time non-fixed term job. We managed to get some funding from various sources to support for short-term post with the Centre. He took this massive big risk and jumped out of this job into the university, where he had 18 months' worth of funding on the table and nothing thereafter. There was money through one of the regional Arts Councils, and there was money from some of the health trusts for which Mike did some scoping studies and and lit reviews. Well it was frightening: he was putting so much faith and belief in the field, in our capacity to work together and extend this. Having Mike there working with me in those early stages was just an extraordinary thing to happen really, and we did manage to get more funding. And we were able to continue his post

through the strategic award as well. And Mike brought in other people, such as Mary Robson, who's become very important to the Centre and our field as well.

Finally, perhaps a personal contribution has been my own relationship with disciplinarity and with clinical practice. I suppose I've always felt that it's important to listen, partly because I don't feel I know things, having had this very peripatetic disciplinary background. I took my degree in English and History, then studied Medicine, then I took a PhD in Philosophy in my spare time without having a background in Philosophy. I've dodged between disciplines. It's amazing to work with these people who really are disciplinary grounded, and I sense how much you can learn if you are open to that. Yet I think perhaps, as a focal point for gathering a community at Durham, it's possibly been useful to have somebody like me there, because I've got the kind of legitimacy of the clinical work, which has always been a feature of what I do. So a kind of connection with the real world at the clinical coalface. People are attracted by that, but at the same time don't feel threatened: I'm not a bigwig in any of the disciplines, so people can perhaps tell me things that I need to know. Disciplinary legitimacy is an absolute prerequisite for good interdisciplinary work but you also have to have someone in the room who can see the larger picture, and who can also see where the work might go to make a difference to health.

RD – That certainly sounds like an asset for the people being part of the community, but it might not always be such an easy position to hold, or perhaps such a stable position. What did you find difficult or even painful about the role of being a leader or manager in this context?

RJM – Yeah. I think I spent quite a bit of time being anxious in the early years of the Centre. I mean I think of one particular example: Mike's position was an area of anxiety to me because I felt I'd made a big commitment in asking him to join us without a lot of funding being available, and feeling I'd made a commitment to him in that sense. A second point of anxiety was that I'd got this big grant from NHS Estates to research the impact of design and decoration at the new James Cook hospital in Middlesbrough, which was being redeveloped with a big new atrium and interesting artwork through the hospital. I'd

appointed a post-doc to do work on that, and I actually had drawn in a group of researchers, two of whom were from anthropology. The anthropologists were the ones that were supposed to be supervising this post-doc, but I think because I was the PI on the project she became much more connected to me. She was doing interview and questionnaire work on the ground. I spent a lot of my time on that project feeling very out of my comfort zone. It was the first reasonably sized project that I had been the PI on; I think it was just shy of two hundred thousand pounds. I really didn't feel at the time I knew what I was doing. I had hoped that in bringing in the guys from anthropology, one of whom was more senior, that I could get some mentoring, but that didn't really happen because I think they saw me as the PI. And in the midst of all this I also got married and had my first baby – my one baby. While I was off on maternity leave I starting to get a bit of complaint from the hospital managers who felt that I was neglecting the post-doc. She was in this interesting position of having a room in the hospital, so she almost more connected to the hospital than the Centre, and interacting with and complaining to the hospital managers that she wasn't getting enough support.

I can remember some very, very uncomfortable times, reflecting back on myself and feeling continually not good enough, and not really able to pull it all together. And it was very tricky. What came out of it actually I think was quite strong: we worked very, very hard on the report, we worked on some papers for it, and I think that some good things came out of it. But it did leave me a bit wary, and I think aware that I needed more support to develop in that role. But at that time I'd no idea how to find that support. The university weren't offering career development at that time. Now it seems it's a very different situation. For example, I know Angela Woods has been part of the Aurora programme for management and leadership. And the Wellcome have got a kind of leadership course for young researchers coming through. But none of that was on offer at that particular time, so for me it was real trial and error stuff. And interestingly, even though I was a medic, my research model was much more humanities. My PhD in Philosophy that was a matter of reading, synthesising, thinking and writing an argument. It wasn't about data-gathering or working out outputs. So I didn't really know how to do that kind of research, and yet here I was leading on a project that was actually trying to report on that kind of research. So I began to

think to myself: 'what the heck am I doing actually?' And I suppose in putting together these bids what I was trying to do was show that the Centre could attract money, and to achieve this I was going after the only money that was available for this kind of work at the time. This entailed kind of putting myself into the lions' den and trying my best to do work which sometimes didn't feel very comfortable to me, trying to make use of the data and synthesising it in ways that I felt I could. It was a big, big learning curve for me. But unless you've got money to pay for people to be present to do stuff, what you are building will just disappear .

RD – When you got this anxiety that you're describing, which is a natural and inevitable consequence where you're in a situation of trial and error that feels high-stakes, what did you do with it?

RJM – Well when you're the Director of the Centre you can't go to your colleagues and say, 'I don't feel good enough,' because that feels worse actually, because you know people are looking to you to provide leadership. Corinne Saunders became a good friend, though, and I did talk to her a bit about it. However, Corinne's somebody who's very strongly within a disciplinary context. She was very supportive but I don't think really understood where I was coming from. I think my husband probably got most of it, and that wasn't easy actually because I think I would take most of it home and talk there about it. It became the beginnings of a real issue for me, just not being able to get away from work. I think there was a period where the Centre was really developing, when it felt difficult for me to feel happy and contented when I wasn't actually getting on with the work, because there was such a need I think for that amount of focus. And breaking away from that became a bit of a problem in the years after that. I found taking holidays difficult and made me anxious, and that affected the family. I think I felt that unless I was constantly pushing forward, trying to understand, trying to kind of connect, that things would start to slip back, because I felt I was always needed. I sought some help for this and, though I know I still have a work-orientated nature, I am much more able to step back.

RD – We've discussed the issue of buy-in, how you got buy-in from other people, and in a way we've discussed also the buy-in that you had. This relates to the theme of infrastructures and community, and their capacity to reduce the price of buy-in for others to an area of work. So how did you go about building infrastructures and community at Durham?

RJM – I was always a firm believer that for the Centre to succeed we had to be physically co-located. So when it first started there was just me and a dog, basically, in one room, and then we got an administrator who was in a room next to me, and then we created a post for Mike through a portfolio of funding. We had to move offices quite frequently over those first few years until we eventually got the big Strategic Award, because there really wasn't a space for us. I remember working very hard to continually make the case for an interdisciplinary centre needing that co-location, needing that adjacency.

The other commitment that Durham made, beside my position and co-location, was academic posts. When we were thinking of developing the bid to Wellcome we went and talked to all the faculty pro-vice-chancellors, and asked for their support. Each faculty committed funding, which was really important and significant. And so an even bigger investment was that we had to persuade three heads of department to take on those posts after the lifetime of the Award, which they did.

RD – And essentially to lose a post of their own.

RJM – Exactly. To lose a post. I think it would be a much more difficult argument to make now, actually, in the current context. So the willingness of the university to back us, to see and make something kind of unique about what Durham was managing to achieve here, was very important. I think it came out of a recognition, which was hard-won, that without the infrastructure of co-location and cross-disciplinarity the thing would not succeed.

As well as co-location and posts, another critical source of infrastructural support is administration. So many things that need to be done to keep it all going: It's things like booking rooms, getting travel paid for, organising conferences and meetings, being a point

of contact for people who want to get in touch, all sorts of things like that. The office occupied by that individual or individuals is almost the Centre, is almost the continuity of the thing that you need to take forward. I firmly believe that the reason the Centre has kept going and flourished for the last 18 years is because we've had that continuity of infrastructure: co-location, posts and administration. If you just rely on project to project funding you've got no continuing structure that helps you progress. Some people believe the ideas will take you there, but they just won't.

RD – Infrastructure makes things happen, but it also elicits ambivalence and disappointment. It's inevitable. At the point at which the Centre seemed to have momentum and solidity to it, what kinds of ambivalence have been evoked by that?

RJM – When we got the first Award from the Wellcome Trust, I had this kind of vision that all my colleagues who were part of it would be physically present in the space that we then had, and that we'd have these spontaneous coffee table conversations that would generate ideas and research projects. We tried to make that happen by having regular research meetings, but they were variously successful. And the wish to have colleagues physically present in the Centre didn't really work because in busy academic lives people need a specific reason to be somewhere. If there's some other meeting in their own department then they cannot stay around just to be there and hang out in case something happens or in case a really interesting conversation takes place. So to me that was a disappointment and a frustration. So I've had to change my view on making a community at the Centre and think again on it.

Another key issue is that success makes people feel that you don't need any further support. When the Strategic Award came to an end I thought the university would step up to the mark, at least to continue some of our infrastructural support, for example with administrative support that we needed, but it didn't happen. And I thought, we're going to collapse without an administrator. And I was astonished actually in a way, after all the success, and at the point when the first Hearing the Voice project had actually been achieved: another big project, a nigh on one million pound project, and the initial award

had been just under two million. I actually had to go on hands and knees, almost literally, to our pro-vice-chancellor for research to find ten thousand pounds to keep our administrator going for two days a week for a year. And I had to do that for two years running, because there was no commitment to that continuing infrastructure, even though they knew there were other projects in the pipeline which were going to yield results and that there were benefit to supporting work that was attracting Wellcome investment. The Strategic Award had provided support for the Centre infrastructure, but that ended and we could not use specific project funding to support the Centre adminstration as that was all earmarked to support the project. Were were therefore in this strange postion of being wildly successful in bringing in funding but unable to support the structure that had brought this about! So there was that real difficulty.

Another potential source of ambivalence related to infrastructure relates to the sense of the Centre and its projects. We recently went for the big Wellcome Trust's Centres award and we didn't get that, and fine, but we got a really generous grant. There has been real conflict about how that would be spent. One argument went that all of it should be spent on developing research projects and doing research, with any of us, of the six of us that applied. By contrast, my argument and some of my other colleagues' was that actually we need to spend about half of it making sure that we had the right people to be able to take the Centre forward, to manage the research, to facilitate the research, to connect with stakeholders inside and outside of academic, to do the kinds of things a Centre does: training, developing careers, hosting workshops, facilitating research project development – not just our own. So I think we had a bit of a conflict between a collection of projects notion and a Centre notion. Having started with the Centre which led to the projects I was clear which route we needed to take, and fortunately that prevailed.

If it was not for the Centre these projects wouldn't exist. Now what is it about the Centre being there that enables these projects to exist? Well, one of the things very pragmatically that enables that to happen is that we've got somebody who's able to organise for people to come together, and make sure they've got coffee, tea and all the rest of it, and a space. That's important. But the other thing that enables it is that the Centre creates a structure

whereby you've got researchers with time to start to think these big ideas, to start to make the connections.

What I'm very committed to building is a space where we have people, researchers, with time to think together, with access to people who can help facilitate the meetings they want to have with other people. For that, we need people like our Creative Facilitator Mary Robson, like other people that we've got working in the Centre such as our Research Manager, Sarah McLusky. And even if there is no big project associated with the Centre for a period, you need that ongoing structure for the the potential for such things to happen with any dependability, and for Durham to remain identified as a place where this is going on.

RD – That leads me to a question that is very dear to my heart, which is the issue of slow research, and the dangers of work in this area not adding up to something. So it feels to me like medical humanities in its potential openness and interdisciplinarity, doesn't have a set of tracks leading it to a particular destination. And as a consequence it has the prospect of working less efficiently, less directly, than disciplinary-based research. For early career researchers that can be especially problematic. So I'd be really interested in your reflections on how you handle the dangers for individual careers and for institutions of slow research.

RJM – First, I would like to respond to your idea of putting down tracks, because it's particularly through my current project, Life of Breath, that I've been beginning to realise how you lay down those tracks, which for me is about at the very outset starting to connect with the people that you feel are going to be most intimately influenced by what you're going to do. This could be clinicians. It could be people who experience the issue that you're interested in. It could be people who are involved in policy. So learn how and where to lay down tracks for a project when you start to connect with those people. But having done that it's still a heck of a lot of work to try to generate those connections, and support the value that comes out of those connections, In particular, what those connections do is they raise questions that people own and feel are important. But making the connections

takes time. Life of Breath was about two years in the preparation before we actually applied.

A problem then, of course, is that you start to pursue some of those questions, and then you realise that you can't pursue them all. There's all this other stuff going around, you can't follow it because there's just too much, because an awful lot of energy has to be put in to making that one thing matter and have a benefit. This process of generating questions, thinking about how you want to answer them, narrowing down, poses the matter of where you think it's going to lead, and that amounts to laying down tracks. We've started to develop a way of doing that in the Life of Breath, asking ourselves explicitly: where are we at at this stage? Where are we getting to? Have we got there? What's been the problem? What's the next stage and are we getting there?

However, when you have got all these stakeholders, you've got to speak to them all in terms of different outputs. It might be blog posts, it might be presenting at a patient group, or it might be writing a publication for a clinical journal and a humanities journal. So the diversity of ways in which you have to get things out there can be very challenging and time-consuming. This poses particular challenges for early career researchers. If they want to continue in academia, they will likely be looking for disciplinary jobs, which require discipline-specific publications, on top of all this other stuff. So it's a big, big ask.

RD – I hope you can forgive me for phrasing this as an accusation, but this is the accusation I myself experience and fear: that an excellent, high quality medical humanities project that produces work that the PI can be proud of is one that always has a threat of harming its early career researchers in terms of their future career prospects, because a good medical humanities project overall is trans-disciplinary in vision and output, and a good post-doctoral career trajectory has to retain disciplinary intelligibility. How do you address this in your Centre?

RJM – I think that's a fair accusation. The academic context we work in increasingly demands high quality disciplinary research outputs because of the prominence of REF and its continuing lack of commitment to interdisciplinarity. Impact helps but not really those in

early career stages. My experience of postdocs in my projects has been that they sometimes do struggle to move onto the next post, and a few step outside of academia. Now in mitigation, shall I say, two things. One is that I think personally I've given a lot of support to my post-doctoral colleagues in applying for other jobs when they want to do that. So being very aware of that risk, feeling that there's that give and take thing; if people are working hard for me I'll work hard for them.

The second thing in mitigation is this really big commitment I feel that we as a Centre have to the development of careers. So we've had two big projects, we've had the AHRC/Wellcome funded New Generations cohort that I mentored for a couple of years between '14 and '16, so we'd 14 early career researchers and we took them through a year's worth of workshops at different institutions around the UK and Ireland. The opportunity to apply for funding or this through the AHRC Collaborative Skills Development call arose in 2014 just as I was developing the Life of Breath project. It was a bit of a tall order to apply for this at the same time as that project but with our commitment in CMH to early career research development it was an opportunity not to be missed. We had a open call for recruitment that included opprtotunties for our own ECRs to apply but in the event all but one of our cohort were not from Durham. Wellcome gave us some additional funding so we could recruit more ECRs and the response to our open call was overwhelming! And the main aim in that was firstly to create a support peer group amongst that lot of researchers, because I mean there aren't that many of them in any one institution. The second thing was to showcase a range of potential career options, and to discuss that, so that people felt there were other options available to them. And the third thing was to showcase them, to medical humanities centres around the country, to say, look, here's a group of fantastic people. But I think it also had the benefit of enabling those individuals to start to reflect about why they were in this discipline. What was it? Now I've heard some of them talk, because the great thing about it is we've kept in touch and some of them have run workshops that I've been invited to come and talk to, and they've been saying things like, they've reflected a lot about, why is it that they want to be in interdisciplinary work? And it's because traditional academic work doesn't entirely suit them because they feel they've got a commitment to do some good directly in the world through their work. So they want this translational element

to be a strong part of it, and they feel very often that doesn't go neatly with the kind of pursuit of a discipline-based academic ideal, and is a better fit with medical humanities.

RD – The issue of hiring also raises the issue that the disciplinary framework for identifying value and quality might not always be suited to a medical humanities context. I'd be really interested in your reflections on the history you've had of hiring people into this area, what you feel has gone well, what you feel hasn't gone so well, and any strategies you use to address it.

RJM – Yeah. Well certainly my first sort of big experience of hiring was for the three posts for the Strategic Award in 2008. The project, as I mentioned before, was entitled Medicine and Human Fourishing and aimed to investigate and outline what contributed to a really flourishing life, critiquing the assumption that health was a key component. Our aims was to appoint three academics in three key depatments involved in the bid: School of Medicine, Pharmacy and Health, Engish Studies and Geography. We just went about the hiring in the normal way that you do, by having an interview and presentations. And one of the biggest challenges actually was when we appointed Angela Woods, and she was appointed to the School of Medicine, Pharmacy and Health, and when we hosted the presentations for that post the audience was tiny, partly because of the location, which was in Durham and the rest of the department's at Stockton, which is a distance away, and because of the philosophical content of it (Angela was trained in philosophy as were a number of rhe applicants); nobody from medicine was interested in it. And I tried to get people from other disciplines, other departments, to come along but that didn't really work. So the sense of there being a community that that individual was speaking to was just not present, so that felt uncomfortable. We made a stellar appointment, that was great. But the reason why that didn't work for all three posts was what the process did not do was enable us to assess the ability of the individual to work in an interdisciplinary context. The traditional process was unable to reveal whether the individual able to be a listener, wether they had the humility to pay attention to somebody else's disciplinary background, methodology, whether they felt sufficiently humble about their own knowledge to be open to something else. We had a bad experience with one of those three posts precisely, I think, because the individual felt continually threatened by the fact that they were in a context

where other people had superior knowledge in other fields, despite this being natural. This taught us a lesson that we would need to adopt a different approach to hiring staff.

We tried that different approach for the first time with the appointments of the post-docs for the Life of Breath project. Our strategy was to open out the experience of a research group meeting to the candidates. Now this was challenging because we didn't want to make it part of the interview process but nevertheless we were actually going to be experiencing how people were acting in that space. So we did it, and what we did was we really showcased – and again Mary Robson comes into her own here – how it is that we work. We used visual methods to get people thinking about the issue of breath, asking candidates to draw a map of their knowledge or their thinking in that area. People found it a lot of fun, so there was a lot of humour going on, people were commenting on each other's drawings, so there was a kind of atmosphere created of friendliness and generosity which worked very well. And what didn't happen, which is one of the things I feared, was the sense of the different candidates kind of eyeing each other up. There were quite a few people in the room and they didn't necessarily know who was candidates and who were not, so that worked quite well. And the nice thing at the end of it was that when we appointed the people we wanted to appoint we got some fantastic feedback from the other candidates, who said, 'I know I didn't get the job but actually I got a lot out of this.' And we've just used the same stategy again last week, reappointing to one of those positions.

RD – Can you draw out the principles at stake here in terms of what it is that appointment to a medical humanities post requires that's different from the qualities that are revealed in a more standard interview, where an applicant is assessed for a more disciplinary-based post?

RJM – I firmly believe we need people who are good disciplinarians, so that our work cannot be accused of the superficiality that can so easily be part of interdisciplinary research. Skimming over the surface of ideas can make it easier to bring concepts together, but interdisciplinary work is harder than this. What is demonstrated in a formal interview is that people can think; that they have experience of the aspects of teaching, research and administration that you need in a discipline; that they understand the key concepts and

methodologies of the discipline and are familiar with its canonical works. What's different in the medical humanities is that they must have, first, a generosity of spirit to share that knowledge and approach with other people, which is time-consuming and sometimes difficult to do, and they must be able to explain it patiently, in words that are understandable to people outside of their discipline. Second, it is important to get a sense of how well can that person interact with people who are not part of the academy. To a certain extent I think you can assess that as well. And the third thing is: how open are they to listen to other people who are trying to explain where they're coming from in that space? And then fourth, how good are they at synthesising that connection? How excited do they get when they start to find things beginning to connect, when they see something new emerging from that connection?

RD – We've been discussing some very positive things but also some difficult things over a number of years. If you could go back and have your time again what might you consider changing?

RJM – [Pause] I think I would like to tell my younger self not to be as worried. I think I've been reticent about taking on roles because of a feeling that I'm not really sufficiently up to it. So for example I didn't take on the role of being the first president of the Association for Medical Humanities because I thought I was too junior and I wasn't up to it. I took on the role of secretary instead. I'd chaired the committee that set the Association up, and yet I didn't take that extra step. That was about confidence and belief in myself. And I think perhaps, and this is tied in with it, I would tell myself to me less worried about disciplinary lightness, making more of a virtue of the fact that yes, that I have crossed over a number of key disciplines, that there aren't very many people like me.

So how would that have changed things practically? Within the university, maybe would have been less reticent about asking for more from the university for a Centre as successful as ours. I think I've tended to have the belief that I wouldn't get it. Yet, having said that, I don't know that being bullish would have enabled me to achieve what has been achieved, perhaps. There has to be a balance between not making a nuisance but also standing up for

what we've achieved. In fact, overall, when I look back I'm astonished actually that the Centre is still here after 18 years, that it is in the strong position it is in.

RD – Following on this discussion of dilemmas about making appeals to one's own managers: if you could go back again, or give yourself some advice when you were setting out as a Lecturer in Medical Humanities at Durham, what advice would you have or what would you do differently in terms of managing colleagues?

RJM – I think at the outset I would be – this is particularly about people one hires at whatever level – I'd be much clearer about what was expected. I think it's all very well to say you appoint some stars and just let them fly, but I think for me now functioning in the Centre as it is I have a very clear sense about what I would actually quite like each person to do.

RD – This sounds at first sight like a paradox because medical humanities has an ethos of openness, you described iterative processes, and yet now you're also saying about having clearer expectations at the beginning, so how do these fit together?

RJM – Well the example that I'm thinking about at the present moment is roles within the Centre. Now these are not new colleagues, some of these are colleagues I've been working with for a number of years. But we had an away-day a couple of weeks back and I was sitting through the away-day feeling very frustrated thinking: 'there's say four or five critical roles in the Centre that I need people to stick their hands up and say they're going to do', and throughout the day I was waiting for people to stick their hands up and say, 'I'll do that, I'll do that.' And when it got to an hour before the end of the awayday I eventually said, 'Look, there are these four or five roles I need people to do, and they are these, and these are the people I think need to do them.' And when I said that I was astonished because my colleagues round the table started scribbling down notes with an attitude of 'right, OK, we'll do it'.

I think I have always been reticent about asking people directly to do things. In the preparation for the big Wellcome Centre bid I went round to some other Wellcome centres and talked to the directors about how they ran things, and these were all biomedical science centres, and my God their approach was different. But then when you actually think, having had the experience you think, those are the things that need to be done, and people need to do them, and you say, 'This is what needs to happen and I think you're the best person to do that, you're the best person to do that,' people actually like a bit of direction and certainty in the midst of busy lives. And so actually I think I'm learning, at long last, that actually you've kind of got to direct sometimes. Perhaps (reticence again!).

RD – Is there anything else that you'd like to mention in terms of these issues of leadership and management in medical humanities that we've not covered, or that you'd like to return to, or that you'd like to address in more depth?

RJM – Well I suppose the only other thing that perhaps we haven't really covered is thinking about the future and the legacy, which I think we've kind of touched on really in terms of the importance of infrastructure. Something important about the medical humanities is, as I have said, that it can show that the evidence base that influences healthcare needs to take into account a wider range of knowledge, of methodological approaches. And clinical people need to both understand this and be part of the change. I think the field of medical humanities as it's developing is occupied very largely by people doing arts and humanities, social science fellowships and PhDs; there are barely any clinicians. When I die or retire or whatever I don't want to be the last of my kind. Now there's no doubt in my mind that there are clinicians out there who are interested. So one of the things that I'd like to try to develop is some kind of infrastructural support. Perhaps this could be part of F1 training. Or there could be fellowships that enable clinicians to train as researchers in medical humanities and take that out into the field. I would like to see study of medical humanities become a legitimate way for clinicians to develop their research career. So that's an infrastructural thing that is an ambition for me I think.

RD – It would imply that there's something that nurtures medical humanities from having input from people who are practising clinicians which is not available to people like myself who are non-clinicians. I'd be really interested to hear what it is that you think is specifically brought to medical humanities by an experience of doing clinical work.

RJM – Well, one factor is that it enables me to be legitimate amongst other clinicians when communicating what medical humanities is about. But I think reflection on the space of clinical consultation has been something I have especially gained from having my dual role. Now that has to go with a real sense that it's a very limited experience, and that sometimes when reaching back into my past life as a GP to get at some of it there's a limitation there. But I've been thinking a bit about some patients who came to my colposcopy clinic, and how it is that even in that very specialised clinical context you can notice things that relate to the wider lives of patients that are deeply relevant to their experience in the clinic and their ability to cope with the stresses of an intimate examination. If I hadn't been working as somebody with a research interest in medical humanities, coming together with my clinical practice, that observation never would have happened. So for me as a clinician the research profoundly enhances my clinical work. But the questions that drive my research absolutely come out of that clinical space, increasingly so in fact. The clinic gives me material to work with, that's live, that's really tangible, that you really can get your teeth into, and it puts me in a good position to ask questions.

Many thanks to both Robbie and Jane for this fascinating interview. For more information about **Medical Humanities**, *please see the blog and Journal website.*
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