Episode 8 Transcript

Topic: Clinician-led evidence-based activism

Hosted by: Leyla Noury

Guests: Dr Piyush Pushkar and Dr Louise Tomkow

This transcript has been edited for clarity.

00:01

Welcome to Mason Institute investigates a podcast series produced by the Mason Institute, funded by the Edinburgh Law School. In each episode we investigate current national and global issues involving ethics, law and policy in health, medicine, and the life sciences.

00:19 Leyla

Hello and welcome back to another episode on Mason Institute Investigates. I am Leyla Noury and today I'm joined by Dr Piyush Pushkar and Dr Louise Tomkow from the University of Manchester, to talk about their research on clinician-led evidence-based activism. Welcome to the podcast and thank you both for joining me today.

00:37 Dr Tomkow

Thanks for inviting us.

00:38 Dr Pushkar

Hi, thank you for having us on.

00:41 Leyla

Would you like to introduce yourselves and tell us what led to your mutual interests in clinician-led evidence-based activism?

00:48 Dr Pushkar

Hi, so I'm Piyush Pushkar, I’m higher trainee in forensic psychiatry in Manchester in England in the UK, so working in the NHS, and I'm also a clinical lecturer at the University of Manchester. I was doing my PhD on healthcare activists, so in the Anthropology department; spending time with people campaigning to save the NHS and protect the NHS; so generally, they were people who were campaigning against cuts and privatisation. So that's kind of what my PhD was on and that's what my section of this paper that we're going to talk about, was on. As to kind of what led us to or led me to clinician-led evidence-based activism; I suppose I was kind of thinking about the similarities between my work and Louise's work, and actually Louise and I had spent some time campaigning together on various things. And so, thinking about what the similarities were between what I was working on and what she was working on, particularly thinking about those similarities in relation to a call for papers that had come out from Flora Cornish, for a special issue of critical public health. And so, we put together this paper based on thinking about what we could see as patterns in the various kinds of activism that we were both participating in.

02:04 Dr Tomkow

So, my name is Louise Tomkow. Like Piyush, I'm based in Manchester, England, UK. And like Piyush, I'm also an NHS doctor. My specialist interest is older people, so I'm a geriatric medicine registrar, but I also am an academic clinical lecturer. And that means I spend 50% of my time doing research at the university in Manchester. Like Piyush, I undertook a PhD back in 2016 through to 2019. I did my PhD, which I think is the same years as Piyush; six months or so difference. And that my PhD looked at the health experiences of all the asylum seekers and refugees. So, I guess my interest in activism came through that PhD and through a masters that I did before that PhD, my PhD was based at the Humanitarianism and Conflict Response Institute at the University of Manchester. And I guess I got involved with activism through my interest in health inequalities and specifically migrant health. And at the time, and I think still possibly more pronounced now, the government was starting to introduce or expanding its introduction of bordering within the NHS using hospitals and GP's and sites of healthcare as sites of borders. So, they were introducing border controls into the NHS by charging certain migrants for health care and asking for payment upfront, which was a new thing in 2017. And this introduced questions of eligibility into the health service, and I didn't care much for this at all, alongside many of my colleagues and friends, we organised around this as Piyush described.

03:42 Leyla

What does clinician-led evidence-based activism mean and how is it different from typical evidence-based activism?

03:49 Dr Pushkar

So, evidence-based activism was a term that someone called Rabeharisoa came up with, or at least that was the first time that we had seen this term being used, "evidence-based activism." But it was all inspired by something that Louise and I grew up with at medical school; we were taught almost as religion, evidence-based medicine, which sees itself as an apolitical epistemology, that's about knowledge discovery rather than knowledge production and about kind of opening clinical knowledge and clinical judgement, transparency, and scrutiny. The knowledge that is developed through this paradigm of evidence-based medicine, is often remains unquestioned, but what Rabeharisoa and colleagues noticed, was that there was a movement of patients and carers who could see that evidence-based medicine seemed to be dominated by authority figures, so scientists, and doctors and other healthcare professionals, rather than patients and carers. And so, they wanted to muscle in on that to equalise the power relations involved in knowledge production. And so, they began to contribute to academic knowledge production as well, and you could see that in the scholarly knowledge that was produced about AIDS and ADHD as well; where patient groups get involved in actually producing knowledge that then suddenly clinicians actually listen to patients once they've got involved in the knowledge production process where they weren't being listened to before, so they called that evidence based activism.

So, the point that Rabeharisoa and colleagues were making, was that it's possible for people who weren't previously acknowledged as having the legitimacy to contribute to clinical knowledge, that it was possible for them to get involved in that process, and so to equalise the power relations within knowledge production. So, then kind of comparing that to what we noticed in our forms of activism, we doctors were being put forward as the clinical authority in the forms of activism that we were getting involved in and observing. And so, it wasn't really about equalising power relations within the knowledge production process. It was about using the authority that doctors already had, and not questioning that, but instead making use of that clinical authority to further some other progressive cause.

So, in my own research that was kind of protecting the NHS, or saving the NHS, or campaigning against cuts and privatisation in the NHS; I was working with groups that often had a doctor in the activist organisation or a number of doctors, and they were the people that were often put forward to make the argument that something bad was happening and that we should object to that thing, so whether it was a cut to a local service or a service thing privatised. So, the group would come up with arguments together, but then it would be the doctor that would be put forward to actually make that argument to the wider public, to the media, etc. And so, this wasn't really about equalising the power relations inherent in knowledge production. It was about using what we call the symbolic capital of the doctor, to advance some other progressive cause. And we were just wary of what happens if you don't question the power relations that you're trying to make use of, and are you running the risk of consolidating that inequality and symbolic capital between the doctor and the other members of the organisation?

07:28 Leyla
So, Louise, your research looked at health inequalities and migrant health, and you also got involved in activism regarding migrant health. I am interested to know what the position of doctors is in migrant health activism.

07:43 Dr Tomkow
So, I guess in terms of the position of doctors within the migrant health activism case; when I was doing my PhD research, I observed the power imbalance, it's quite clear the power and balance between myself as someone who is born in Manchester; has citizenship; is in a professional role; and then interviewing people who live in a much more precarious situation and much less social capital, but really marginalised by the hostile environment and that's a very purposeful political strategy. So, I both observed that, but also some of the people I was interviewing, so that all the asylum seekers and refugees would say to me, “the reason that I'm sharing my experience with you is because I want you to do something about this. I think you can help people.” And often, a little overstating my reach, but they perceived that this research could have a huge, huge reach and people were asking me to meet the Home Office and change the asylum system. But so, in the same way that Piyush described doctors were being put forward for those, for leading the research, or leading the spread of the message, in some ways; people are asking me to do that as well, the migrants themselves were asking me to do that. And we did that strategically as a group as well, as a campaigning group. So, we organised around a group called Medact, and we produced research, produced evidence, to prove how problematic the policies of charging migrants for healthcare was, and we did that by interviewing people and taking survey data from doctors about their knowledge and

awareness of different immigration categories; were they aware of what the charging meant? And we demonstrated through that research that there was a huge gap in knowledge, and our argument was that therefore that's an unworkable policy and it's dangerous, and we did that through these archaically legitimate channels.

So, we published through academic journals and strategically did that and then disseminated our findings more broadly through blogs, through talking to mainstream media. And I guess that again, is strategically drawing on that social capital of the doctor, and of the institutions and that the legitimacy that that historically and still gives in order to campaign, and I think being candid about it draws attention to the power dynamics and how problematic that is, and the idea that I am more qualified to share a story than the person who has actual lived experience, actually is quite bizarre.

And I think my PhD really allowed, even encouraged, a period of reflection, and one that I don't think clinicians normally are afforded with because people are just so busy. But it asks you to think about your positionality as a researcher. The biases you bring, but also alongside that the privilege that you occupy. And I found that a lot the research work that I was doing, but also the activist work that I was doing, a lot of it was talking or along the lines of “giving voice” into two lesser represented communities, marginalised communities, underserved communities, and I felt this was really problematic. It didn't sit well with me, and I thought it was, reflective of wider social inequalities and privilege, and my sense was that research could be quite extractive and also activism in some ways could be quite extractive as well. I think for me that's where those informal conversations, were the idea that CLEBA came from and looking back, I can see that going through the paper now and I think the CLEBA paper had more of a structured analysis of that.

11:31 Dr Pushkar

I suppose it's very easy for doctors to fall into a hero narrative of using our, what we might consider, or do consider, our expertise and our position to advocate for those who don't have the same privileges, the same material benefits that we have, the same class position, the same power, the same influence, and think of ourselves as doing something good with the authority that we have, so making use of that position. But the point of this paper was to question, what else is happening and what other work are we doing, if and when we contribute to activism in that way? And what problems might there be with thinking of ourselves as the good guys, and the heroes, and the people who are going to do good for everyone else rather than with everyone else?

12:20 Dr Tomkow

Absolutely. I think it's that for rather than with, that's the crux of the differentiation between clinician-led evidence-based activism and evidence-based activism more broadly.

12:30 Leyla

So, in your paper you are exploring a tension between legitimacy, credibility, and authority. Could you expand on what the tension was?

12:41 Dr Tomkow

So, I think the issue of credibility for the asylum applicants that I was speaking to as part of my research was highly, highly consequential; it was very, very important, and that was a theme that threaded throughout my research, and I think the parallels between both mine and Piyush's work and that the people that doctors were working with in the activist campaigns, were both either delegitimised or had their credibility eroded. But my work argues that credibility is particularly important for migrants and asylum applicants in particular. I think throughout people's asylum claims, throughout the procedure, asylum applicants have to present themselves to the Home Office in a way that they seem legitimate and the only way that the Home Office decision makers delineate between what they consider to be genuine refugees, and those that they consider to be not genuine and therefore will end up being categorised as failed asylum seekers or illegal immigrants, is through a assessment of people's credibility, and this has been written about in the literature a lot and problematised a lot. The media obviously still today and at the time, construct asylum seekers as being welfare cheats and asylum shoppers and bogus refugees. In short, the difference between a successful application and therefore someone being allowed to remain in the UK as a refugee, and an unsuccessful one at the time, was whether the Home Office found people’s asylum accounts to be credible, so credibility is really central.

One of the central cruxes of our ideas about clinician-led evidence-based activism is that clinicians positioned as a credible and legitimate authority, lend that credibility to the activists that they're working with, or the underserved groups that they're working with, in order to reach that shared political goal, that shared activist goal. So, it's a way of consolidating that social capital.

14:34 Dr Pushkar

Rabeharisoa and colleagues, their initial description of evidence-based activism was all about the patient groups and lay experts starting from a position of being illegitimate speakers. And so, they had to kind of find some way to influence clinical opinions and clinical knowledge production. So, their way was to make themselves legitimate speakers by contributing to scholarship, and that was their way of changing clinical practice and it was activism in that sense. It was evidence-based because they're contributing to scholarship. But we kind of consider legitimacy, as Louise was saying, as a kind of symbolic capital which helps to shed light on how legitimacy, the way in which you're deemed legitimate, kind of accords with certain norms. But the people who have greatest influence over those norms in the first place are already powerful.

So, these things legitimacy, credibility, authority, are all acting synergistically, so the people, migrants, asylum seekers, etc are starting from a position of already being illegitimate speakers, and then they're further delegitimised by these attacks on their credibility, by attacks on their relevance. So, NHS activists were accused of shroud waving, so the more NHS activists worry about cuts and privatisation, the more they're criticised for shroud waving, for conspiracy theorising, etc. And so, it's a strategy to regain some authority and legitimacy, and credibility, to attach your arguments to a person who already carries authority, legitimacy, so to a doctor. But then that leaves the question of why it is that the doctor carries that authority. It leaves it kind of unasked and unquestioned. And so, the class position of the doctor is kind of further consolidated by this appeal to his or her authority.

16:39 Leyla

And Piyush, in your other paper you examined the moral arguments of a similar type of activism – NHS activism. Are the features you observed in the moral arguments driving NHS activism the same in CLEBA, and if so, what are they, and if not, how are they different?

16:57 Dr Pushkar

So the paper you're talking about is the moral economy paper in Medical Anthropology. Is that right?

17:04 Leyla

Yes, that's the paper.

17:06 Dr Pushkar

So, it's based on the same research from my point of view. So that paper in Medical Anthropology is a paper that I wrote based on my research only. So not including Louise's research on migrants. So yes, I'm looking at the same kind of activism, the same healthcare activists campaigning against cuts and privatisation. But there's a difference in how exactly I’m looking at it, because in that paper there's kind of key differences that I'm focusing on, the kind of consciousness and the way in which activists are focusing on moral arguments that contribute to a particular understanding of what their interests are. So, what their material interests are, and how those conceptualizations of what their interests are, can contribute to alliances between different activist groups. And so, I was writing that paper kind of shortly after the junior doctors strikes happened in 2016. Rather than looking at the symbolic capital of doctors, I was looking at what their professional interests were. So in some ways, the kind of the consequences of looking at things in that way were similar because again, there was a group of healthcare activists campaigning against cuts and privatisation who were aligning themselves with a bunch of doctors. But rather than looking at through that lens of symbolic capital, instead of looking at it through the lens of interests, allowed space to see things a little bit differently, because it allowed me to think about their egalitarian potential, at least in those alliances.

So those healthcare activists came to picket lines to support junior doctors in 2016. In 2016, there was a junior doctors’ industrial action because a new contract was being imposed upon us by the then Secretary of State for Health, Jeremy Hunt, that junior doctors opposed. But healthcare activists that had nothing to do with the actual contract, came along and supported junior doctors, and they said they're supporting junior doctors because we want to save the NHS. And so, this industrial dispute became framed in a different way of being about saving the NHS. And so, the kind of narrow professional interests of doctors became conjoined with a much wider interest group, because protecting the NHS is about protecting the interests of the whole population, like everyone that can benefit from NHS. And so doctors saw the potential in this alliance of forming a much broader coalition with other people, broader and therefore stronger and activists saw the potential in aligning with doctors who already have a special position in the nation's politics. And so, there was this potential for the consolidation of interest and therefore solidarity. And so, people were working together wasn't about doctors being put forward as the heroes necessarily. They just happened to be at the forefront of that particular movement because it was an industrial dispute for junior doctors. And so, there was that potential there. So, we're speaking on the 9th of March, and junior doctors are just about to go back on strike on the 13th, 14th, and 15th of March, so next week, at the time of speaking. And so the dispute this time is about pay so junior doctors have, like most public sector workers, have had our pay eroded over the past 12 years or so, in terms of real wages, so in comparison to inflation, we've had about 26% pay cut and so this dispute is about pay and the arguments have been building over the past year or so or probably longer actually, to campaign for pay restoration amongst doctors.

But this time around the link between campaigning for better pay for doctors, so campaigning for the professional interests of doctors, the link between that and other unions and also with saving the NHS, has been at the forefront throughout, so it hasn't been something that healthcare activists brought to junior doctors. So, the reason I'm mentioning that is because it seems as if the collective memory of struggle from 2016 has had an effect on how doctors see themselves. What was a potential for seeing our interests as aligned with a broader kind of community of interests has now been realised. It's no longer just potential. It's had an effect on how doctors understand ourselves. And so, there was something good and egalitarian about the effect that the coalition that was formed in 2016 has lasted to some degree.

21:41 Dr Tomkow

I think that's really interesting. I haven't thought about it like that at all. I wonder whether was there a degree do you think in 2016 of the NHS activists who are campaigning to save the NHS, capitalising on the social position of doctors and the struggle of doctors in resistance to their new contract? Do you think there was some borrowing of legitimacy at that point, and if so, does it matter if this is the final product of it, and if not, why not?

22:14 Dr Pushkar

I think that's the tension. And so, the paper that Leyla is talking about, the paper in Medical Anthropology, does talk about the potential that egalitarian potential, contrasted with their worry of, yes, but if doctors are aligning themselves with others on the basis of professional interests in which we consider ourselves to be particularly important to the NHS, so perhaps more important to the NHS than other people, then there's something that isn't particularly egalitarian within that logic. And similarly, the clinician-led evidence-based activism paper is very aware of what happens if you strategically use your authority, even if you're using it for some progressive cause, are you embedding and consolidating unequal hierarchies? And you know the thing that I'm quite proud of what we managed to theorise in the clinician-led evidence-based activism paper, is that there's never an end point, and so you just have to be aware of the way in which your tactics at any particular moment can have a number of different consequences that can consolidate unequal power relations; even while contesting other unequal power relations, and so it’s a danger that we have to be aware of. I've just kind of highlighted a positive from the way in which coalitions were formed in 2016. There are obviously other things that will have contributed to the way in which alliances between unions are being formed at the moment and. Obviously, we just had the big strike summer of 2022 and I think there were going to continue to be strikes and, you know, solidarity between the various unions in 2023, but what we've kind of highlighted in the clinician-led evidence-based activism paper is the dangers inherent on relying on the authority, legitimacy, power of doctors as doctors.

24:14 Dr Tomkow
Absolutely.

24:16 Leyla
So, you both examined CLEBA in two situations. The austerity measures affecting the NHS, and the legislative changes to NHS targeting migrants. What was the role of CLEBA in these two instances and what were the subsequent effects?

24:32 Dr Tomkow
So, I think the role of it was to try and challenge the political environment, and I think that was the overall aim is that everybody involved; so the migrants themselves and the doctors who are taking part in the activism, felt that things needed to change, and by things I mean, there

were very particular policies that were being enacted that we felt shouldn't be in place and we wanted reversed. I touched on this earlier, but we strategically developed research papers which evidenced the unworkability of the policy. We published those in academic journals. We presented those at conferences; we spoke about them to our peers; we published blogs; we published in more mainstream media; we organised protests outside hospitals, and I make it part of my education and teaching now still. So, telling other people about it, telling medical students and more junior doctors and more senior doctors as well, about these charges and the harmful effects of them. I think all of those actions are all very well and I think this is probably something that crops up again and again in activist conversations, but there is occasionally a sense that you're just screaming into an echo chamber, and actually the people that you're reaching with these outputs already feel the same as you do, and it’s breaking beyond that echo chamber and trying to change people's minds, who I'm guess are in positions of power, or might think differently, is really the challenge that a lot of activists face.

In thinking about this, I've wondered about examples of CLEBA in policy and practise and drawing on the case of migrant charge. In particular, I could think of one example, and I'm sure there are more, but around this time 2017, 2018, 2019 there was also a memorandum of understanding between the NHS and the Home Office. And this essentially meant that the Home Office was allowed to make disclosure requests to the health service to access migrants’ medical records, in order to help the Home Office trace immigration offenders and vulnerable people who may be at risk, and that's what the Home Office positioned themselves as doing so. In actuality, this was used to find people who owed the NHS money because they were chargeable and to use that in cases against them to get them deported from the UK. So, this was felt morally to be way off by the doctors and obviously by the migrants themselves, and health records should be confidential. There was a strong feeling that this was fundamentally wrong. And in light of that, there were cases of doctors giving evidence to Parliamentary Health Select Committees about the harm of these hostile policies. So Lu Hiam (Dr Lucinda Hiam), who is a doctor who works at Doctors of the World; I think she now works for the WHO; and she's a fantastically inspirational person as an aside. But she spoke at one of these committees, and she gave evidence. So, she spoke about her practising with the world, and she shared the stories of migrants, so she gave voice to migrants. She told their stories in front of this parliamentary health committee. She lent her legitimacy, her authority, used her social capital as a doctor, and following that and following that committee later, sharing between the NHS and the Home Office was suspended. And that was an example of real-world high-level impact. I'm sure that the papers, blogs, and other things that more grassroots things that we're doing has maybe some impacts in changing some people's minds as well. But I thought that was a really nice example of how CLEBA can be used at national level. Of course, that doesn't take away from any of the problems with it, but it can be an effective strategy.

28:30 Dr Pushkar

Also, just to highlight the clinician-led evidence-based activism can be used in other ways as well, in less egalitarian ways. So Louise mentioned Lu Hiam, highlighting what the problems would be or what the problems were of the charging regulations. But one person that we constantly came up against when we were campaigning with Medact against their charges for migrants in the UK was, I don't remember his name actually, but he was a cancer surgeon who was used by the other side. And even though he was not at all representative of doctors' views, or at least I don't think he was representative of doctor's views, he certainly wasn't representative of junior doctors' views regarding the charging regulations; he was trotted out on the media, every time charging regulations were discussed and obviously he was getting these positions on BBC Radio often; published in the right wing press, on Conservative Home etc. He was being listened to because of his legitimacy as a doctor, as a surgeon who was working in the NHS. I think he did private sector work as well, but I'm fairly sure that he did do NHS work and so he was able to contribute to that. And that's something that I found as well in my own research with NHS activism, and everyone who lives in the UK has been following the NHS will be aware of is, that we've had marketisation since the 80s onwards. We've had austerity since around 2010 onwards. With all of these reforms, they're normally put forward by a doctor so that the politicians can say, actually, these reforms are clinically led and so there's always an element of clinical-led activism. And actually, even with COVID as well, with the responses to COVID. Boris Johnson and Matt Hancock were able to hide behind Professors Whitty and Vallance and say, "No, we're just doing what those guys are telling us to," while not really doing what they're being told to do or not really responding to the evidence in the ways that Professor Whitty and Professor Vallance might have suggested. So, the use of medical authority, medical legitimacy can go both ways, I suppose one way of looking at it would be that within NHS activism, it's not been successful at all, because cuts have carried on and the marketisation has continued without abate really. Another way of looking at it would be that actually things would have been much worse and would have had more cuts and definitely more privatisation if there hadn't been a movement resisting all of these things. And that's one way of looking at it as well. And looking at the movements that have been developed and the kind of consciousness that have developed as a result of movements, and one small bit of evidence regarding that was what I just mentioned about the junior doctors' upcoming strikes and the ways in which junior doctors are understanding our current struggle, as not just about our own professional interest, but also about saving the NHS, because we need more doctors, more nurses, and the only way you're going to have staff retention and attracting new staff is by paying them appropriately, and so all those struggles become conjoined.

31:51 Leyla
And finally, one last question to wrap this episode up, what other ways are there in which clever can be improved upon?

31:58 Dr Tomkow
An interesting point is how can this be improved upon? My read of this is that it will be a movement more back towards evidence-based activism, so away from CLEBA and towards evidence-based activism. Even if it's not absolute, just looking to move towards that. I think using the part that's the knowledge production as a site of power sharing, I think it's an important battle to have and I think it should be something that researchers and doctors are working towards and I think now, I wonder what you think about this Piyush, but I think since I started my PhD in 2016, I think there has been more attention to this from funders, especially. So, a lot of my current research is funded by the National Institute of Health and Social Care Research, NIHR, and the NIHR are very, very keen on something called PPI. So Patient and Public Involvement in research. And there is a huge literature on this and a lot of PPI contributors, so people who are so-called lay researchers - so haven't necessarily had formal academic training but contribute to research a lot, and often the people who do this are people with lived experiences of the diseases or the conditions being researched, are very actively involved in these debates and these debates happen on social media, but they also do happen in journals. But I think that's a very interesting sight of debate about moving away

from clinician-led evidence-based activism more towards evidence-based activism. Now it's possibly less of the activism than the examples that we're talking about. It's possibly more evidence-based medicine or just generating knowledge more broadly. But my current work is focuses on that PPI elements.

So, two projects that I led recently, looked at palliative and end of life care and communication decision making for older people during COVID, one of them specifically looking at people of African and Caribbean descents experiences, because it was a very under-served group, and one that was disproportionately impacted during COVID. And as part of that, we had a PPI consultation group, who we met with three or four times to get their feelings on the research. It was far from being a co-production process. It was more like a consultation process and that again was something that didn't really sit right with me. There's a really good paper called "'A limpet on a ship'" and it discusses how PPI can be badged onto the edge of projects, and actually the ship is the project, and it will be guided by the researchers, who are the people with the real symbolic and actual power, and that the limpet is clinging to the side as the PPI contributors. And I think that again is problematic. I think that doesn't do anything to challenge the power dynamics between research and those they're researching.

I guess in light of that, and working with colleagues at LSE and Newcastle University, we've just recently been awarded a grant that looks at diverse experiences of end of life, care for people with dementia, and this is a co-production project, and we're looking to establish consensus and build capacity for future projects. So, it's quite a modest one-year project. But we're looking to find out what issues are important for people from minoritized ethnicities to resolve and also interested in those people who are living in poverty and material deprivation, which is obviously a huge issue in the UK today. I think the way in which we're going to start to understand those questions is by putting the people who are being researched at the front and centre. So, we're going to have much more in the way of consultation and actually the research will go back to ask these sorts of experts, stakeholders, people with lived experience of these conditions. Rather than going in with set research questions, we're going to ask people, what are the important research questions for people in terms of end-of-life care and dementia, and what are those particular social and cultural issues that we need to consider and how we can meaningfully involve people from ethnic minority communities, different religions and those living in poverty in research, in a meaningful way. So, I think sometimes it's about going back to the drawing board and really trying to unpick those power dynamics and that's how I feel that clinician-led evidence-based activism can be improved. It's about making the people that are being researched or the people whose experiences we're interested in front and centre of the research process and able to guide the research process, is in the beginning of that project, so it'll be interesting to reflect on that in years' time and think about some of the fruitful things that have happened and some of the challenges that will come as well.

36:49 Dr Pushkar

I'm not sure I've had much more to say beyond what Louise has already said, but I suppose the thing with clinician-led evidence-based activism is that to some degree it can work, and it's a common sensical thing to having decided what your goal is in your activism, to have a look at what your available resources are and think, OK, I can make use of this authority that one member of our group has, a particular group of clinicians has in order to affect some progressive goals, so let's do this. And doctors obviously do have some expertise that other people don't have, so we shouldn't ignore that or make light of that. There are things that doctors can do that other people can't, and there are ways of knowing that doctors have that other people have less access to.

So prioritising one set of goals, over another set of goals is something that we're all doing all the time, and that social movements do all the time. And so, what Louise and I are just calling for a bit of wariness about is, that the tactics that you use can themselves or will themselves influence the social structures that we're trying to change. And so, we may end up consolidating power relations that put us on top, by us I mean doctors. We might not question it partly because we benefit from it and we've been talking about symbolic capital and the reason Bourdieu talked about the various forms of capital is because having capital allows you to invest capital and investing capital facilitates you accruing more capital and consolidating your class position, and that's what we're talking about. That's the way we're talking about this symbolic capital that we have and we can lend to other people and that's kind of the investment that we then get back to some degree. And so, our class position as doctors, a) remains unquestioned, and b) further consolidated, so that's the danger.

38:47 Leyla

OK, great. I think that's a good place to end the episode. Thank you both so much for coming onto the podcast to discuss with me your research.

38:56 Dr Pushkar

Thank you for inviting us on. It's been great to discuss our research.

39:01

Thank you for listening to today's podcast. We hope that you enjoyed it. For further information, check out the links in the show notes of this episode. If you are interested in contributing to the podcast, we want to hear from you. Get in touch through social media or by emailing us. See you next time.