

## Podcast – Jo Merrifield interviewing Sean White

### Transcript

*Jo Merrifield* speaking with Sean White

*Time*

*0:10:* Welcome to this episode of *Clinical Research Career Conversations*, brought to you by *Edinburgh Clinical Research Facility*. I am *Jo Merrifield*, and today I'm joined by *Sean White*, a specialist dietician and postdoctoral clinical academic. In this episode, *Sean* shares how his clinical experiences shaped his research journey and how his work has advanced understanding of shared decision making in enteral feeding. He also gives his advice and tips for anyone thinking of a clinical academic career. Enjoy.

*0:50:* *(Jo)* Hi *Sean*, thanks for joining me today. It's great to meet you and I'm really looking forward to hearing about your career. I wonder if a good place to start though would actually be about the role of a dietician, just in case listeners aren't quite sure what a dietician does in healthcare. Do you mind giving a brief description of that role? Is that OK?

*1:08:* *(Sean)* Yeah, yeah. So hi *Jo*. Yeah, dieticians, our role is to assess, diagnose and treat dietary and nutritional problems. The qualification involves usually a four-year undergraduate training or there are shorter postgrad training to get your registration.

*1:24:* And then we can work in a number of settings really. I think most probably go into acute settings to start off with, so working in hospitals, hospital ward, different specialities, supporting people with different types of conditions, but can also work in other settings, so that includes community settings, even in industry, academia, and even private practice. And yeah, I think we consider ourselves a part of the wider multidisciplinary team, so we're working, you know, obviously we're assessing people's nutritional status and delivering nutritional interventions, but you know, we have to do that alongside our colleagues, because it may mean things like we need medications to treat certain problems which are barriers to people being able to eat and drink enough. And so, we're very much part of the MDT.

*2:09:* *(Jo)* Brilliant, thank you for that. So I guess, switching it back to you. So how did you become a dietician and obviously your role has now evolved into doing research. So it'd be really nice to hear how that journey has progressed.

*2:21:* *(Sean)* So I qualified back in 2001 from Leeds Metropolitan University, as it was called then and, as with many allied healthcare professional roles, you often go into a general rotational type post. So I got lots of experience on different care of the elderly, stroke type wards. But then, quite early, to be honest, I then progressed into the home enteral feed dietitian back in 2004, which is a role I stayed in for then 17 years, and that role involved supporting people who have enteral feeding tubes, so feeding tubes, mostly directly placed into the stomach, often referred to as PEGs, who are fed that way, but in their home environment. And people on home enteral feeding tend to have one of a few broad conditions, so post-stroke, where the swallowing's been affected permanently really because of that. The other big group had neck cancer, so again, having a feeding tube because of the impacts of the treatments that they had. There were then other groups like learning disabilities and people with progressive neurological conditions, one being MND, which is where my research sits now.

- 3:26: And that role is something that I absolutely loved. We supported people with their enteral feeding plans to make sure that they were optimising their nutritional status. It was a very practical job, so problem solving, trying to work out how the enteral feeding fits into people's normal lives and how we manage any complications associated with either the feeding or the condition that they've got.
- 3:47: So it's a very problem-solving role, which I really enjoy, and I think that probably is why I also enjoy research as well, because it's exactly the same principles. But we also had an extended role in that one of the ways we commissioned the service in the first place and the way that we grew the service was that we took on being able to replace feeding tubes in the community setting.
- 4:08: So before our service, lots of people were coming into A&E with displaced tubes. That obviously has a huge drain on resources and it's expensive and it's not nice for patients either. Because we were going out to people's homes anyway, by training us up to be able to place tubes in that community setting meant that we prevented lots and lots of admissions, and at that early stage when we were quite a small team, we were probably paying for ourselves in preventing admissions.
- 4:33: And then how it developed into my research interest - we were traditionally a service that saw people post-gastrostomy placement and managing that side of things, but through anecdotally, I guess going into people's homes, seeing them come home on enteral feeding for the first time, we started to recognise that people weren't particularly well informed or prepared for starting that phase for being on home enteral feeding.
- 4:58: And we thought as a service that goes in every day to patients' homes and really understands the intervention and what it involves, that we could communicate that to people who were maybe thinking about having a gastrostomy. So we started to offer what we called a gastrostomy counselling service, which... we weren't necessarily commissioned to do, but we felt it was a really appropriate use of our knowledge and skill sets.
- 5:20: And so that was more for people who were making these decisions in the community setting. So often with some decision making, it's done in the acute setting. So you have ENT, head and neck cancer, they know they're having this treatment and they make that decision in the clinic. But there are also that group, especially progressive neurological conditions, where decisions are made over time and often can be made in the community setting. So they were the group really that we felt we could help inform.
- 5:45: So we started to offer that to our neurology colleagues, and they were taking it up and we were seeing more and more patients that weren't being seen before. And from our point of view, because I had no interest necessarily or knowledge of what decision making was at that point, we were just seeing ourselves as an information source.
- 5:52: Then after a while of doing that, I guess personally I started to question, so am I doing this well, so am I helping people weigh up the options that they've got? Am I doing it in a way that is useful and effective for people to make good quality decisions? And then even what is a good quality decision? And that took me down thinking about shared decision making - what I now know is quite a large evidence base, a way of

supporting people to make decisions that are aligned with what matters most to them. And it took me down that route thinking this is what I should be really doing when I'm supporting people.

- 6:35: But then going down that route of maybe thinking about what's in the literature then sent me to think, what do we know about this in MND? MND is a very unique context for decision making in that people are unfortunately, given a really tragic diagnosis of often being told that they only have, say, two to three years to live. The disease is associated with progressive loss of multiple functions - swallowing, being able to breathe, being able to move, being able to speak - and there's not really many effective treatments which can affect that disease course, and people are making these decisions, and not just about gastrostomy, they're making tons of decisions in that context.
- 7:14: So I started to delve into that literature and realised that there wasn't a huge amount, really, to guide us in that context. So that again sent me down this route thinking we need to understand this better. So back in 2014/15, I heard about the NIHR Clinical Academic Pathway. At that time, the first step on that was the Master's, which was funded by NIHR. So I saw that it aligned with what I'd been saying to my manager for years, that I wanted to pursue some research time in my role. They were very supportive of it, so I applied and I got onto that. For me, I did a full-time Master's in a year in research methods. And so that was just my first real dip into probably getting a good grounding and understanding of research and what research was.
- 8:01: What was amazing about it, you're doing lots of assignments, basically, you know, systematic review assignments or research methods or whatever, but all those assignments where I could do in the subject that I was interested in, which at that time was home enteral feeding and decision making. So that again, I was able to increase my knowledge of my clinical area through doing all this work, as well as improving my knowledge and skills and research methods.
- 8:23: And then I did... my dissertation was a small interview, qualitative interview study which focused on the role of understanding people's values in decision making about gastrostomy. So it was my sort of first dip into sort of trying to understand this phenomenon a little bit better. And I published that paper, so that was again my first doing everything – designed a study, delivered a study, disseminated, presented on.
- 8:45: So then I came back into my full-time clinical role, and I think I'd known then that this was something I did want to do. I wanted to pursue it. And again went back on my agenda with my manager. But I think I was quite clear that I wanted to go on and do the PhD eventually. I felt I needed to come back into practice and try and implement some stuff first. And I was in the right place at the right time and with the right people. So, Sheffield is a world-renowned research centre for neurology and MND research and there's a few profs there – Prof Shaw and Prof McDermott - who have led a lot of really huge research in MND.
- 9:20: And I was able to start aligning myself with that team. So firstly, I got involved in developing an information resource for people with MND or thinking about gastrostomy, but it involved a huge team of professionals, of people with MND, their caregivers, academics, but we designed an online video-based information source of people speaking about making the decision about what life was like on gastrostomy feeding with MND.

- 9:47: And so I think it was quite innovative as a resource and it's still now really commonly used across the UK. That was led by Prof McDermott. So I've worked with him since then, really.
- 10:00: At that same time also, Prof McDermott was applying for a really large NIHR programme grant for applied research, so a multi-million pound six-year project called HighCALs. So this was with the intention to understand how people with MND can be supported to follow high calorie diets. We knew in the literature that there were lots of signals that that was associated with better outcomes for people with MND. So he invited me to be a co-applicant on that as providing dietetic expertise for the group, and I think that's still up there with my highlight of any clinical or academic career, really. It was such a fun time to be at the coalface, understanding the new information, new research coming through. But then immediately applying it into developing a complex nutritional intervention for people with MND that we are now evaluating in a multi-centre randomised control trial.
- 10:52: So the fact that I was involved from just past maybe the conceptualisation of the idea, but certainly with regards to the application, you know, the primary research, the developing the intervention, training sites on how to do the intervention, and now obviously we're coming towards the end of data collection. It was just an amazing experience of the whole research process. It just gave me loads and loads and loads of experience.
- 11:15: So I'm really pleased that I came out of my MSc with this qualification in research methods, but then I was able to absolutely practice and implement it for a few years after that as part of the HighCALs programme grant. But I went back into practice as well, so I was hopefully, you know, informed how I was practising in supporting people making these decisions.
- 11:35: But then sticking with the research bit, then I knew I wanted to do the NIHR doctoral fellowship. I was lucky enough... back then we had a Clinical Research Academy fellowship, I think we called it, but it was basically an arrangement between my Trust and the University of Sheffield, where they paid me out some time to be able to - it was basically bridging money - to develop a competitive application for the NIHR doctoral fellowship. What was amazing about that, I had lots of infrastructure and support around me. I was mentored by, at that time, the lead of the research design service for Yorkshire and Humber, Prof Wendy Baird. She was an amazing source of support and still is. And that time enabled me to, I think, put together a really, really competitive application. It certainly would never have been anywhere near as good as it was without that time and that support. And because of that, yeah, I put an application in and I got the award.
- 12:26: That's what I finished back in September. And now I'm back into spinal injuries - back into a clinical role again.
- 12:32: *Congratulations!*  
(Jo)
- 12:32: So I'm going through that cycle of thinking now, what next?  
(Sean)
- 12:36: *Brilliant. Well, that sounds like a really satisfying career so far. Obviously you've stayed in quite a similar area and you've obviously seen it really progress over the years and*  
(Jo)

*you've been able to be part of that change, which just sounds really good to be part of. And I really like the way that you spoke about how actually being a dietitian, being an allied health professional, you can actually see the real-world problems that are happening around you and that's where the questions come from to then build on your research.*

13:07: It's absolutely the value of having not just AHPs but healthcare professionals. So I  
(Sean) guess we have that experience of the coalface and the real-world problems that we face - that patients face - and we can create our questions out of that. I guess what we don't always have is the research methods knowledge to then know how do we answer that question, and that's where either academics need to come into the equation or we need that hybrid of a clinical academic who's got the experience of both sides of that fence.

13:32: *Yeah, definitely. Are there many dietitian researchers, or are you one of a few, or...?*  
(Jo)

13:37: Yeah, so I think there's... again, I think it definitely is increasing, especially because of  
(Sean) the funding streams that are, again, so much more even now than they were 10 years ago and certainly more than they were 20 years ago. My sense is that yes, there are more dietitians going down this clinical academic path, whether that be NIHR funded or through other routes, through like charity funding or just self funding.

14:00: There are certainly others who are, you know, maybe not taking the formal education route and are still very, still I would say academically active, contributing to studies, being PIs, doing clinical effectiveness stuff, disseminating work. So from a dietetic point of view, I'm on a postdoc WhatsApp group, so someone had the good idea to try and bring us all together. At the moment, I just looked the other day, we've got 32 members on that. I imagine there's a few more.

14:27: I think there are a lot less who have gone maybe further than that, so up to sort of professor level, and I think that's what we need to develop. We need to have that whole people at every stage, and I think the more professors and role models we have who have reached that high level, the bigger teams they will have and the more dietitians and postdocs they'll have under them and blah blah blah.

14:43: *And you spoke about a piece of research that you're still involved in where it's about working with the multidisciplinary team and you've got a huge amount of different professional groups working together. So what kind of professional groups would you see in that team and how does the dietitian fit in there if that makes sense?*  
(Jo)

15:01: Yeah. So I've got two, I guess there's two experiences regarding that team. So there's  
(Sean) HighCALs. So in there, and I don't want to miss people out, but from a healthcare professional point of view, we have Prof McDermott, who is a neurologist, so he was involved. Many of the local MND MDT did support us in some way, whether that's reviewing materials or producing videos. There's speech language therapists, occupational therapists. And then there was also an academic team, so we had psychology involvement as well from that point of view and lots of methodological support as well, you know, running trials, qualitative experts, systematic reviewers.

15:39: So that was the team regarding HighCALs on a big programme grant. Professor McDermott's also got a professorship, and within that he's got a lot of AHPs involved doing PhDs as part of his professorship.

- 15:53: We were assembled as a team as well, so even though we were all doing different work, we used to meet every week. And that was such a positive experience. So in that room, we certainly had physios, OTs, I think there's now speech and language therapists, all doing something different but aligned with the care delivery for people with MND, either understanding it better, developing interventions, developing care models. So we would share what we were doing, get feedback, but it'd be based on maybe a physio's viewpoint or their sort of perceptions, and that would be, you know, such an organic thing which would just always be happening. We went for many, many coffees in our local coffee shop to share our stresses, but also share ideas and develop maybe things that we might want to do in the future.
- 16:37: And I think, you know, having that group together over the three years that I was doing my PhD was so valuable in both the research I did and how I wrote it up, but also I hope that we will be collaborating, I imagine, in some way going forward.
- 16:52: *I can imagine so many different problems were solved that way and stopping  
(Jo) reinventing the wheel and things like that, just having that network of support. That sounds brilliant.*
- 17:02: Yeah, yeah. We were all using different methods as well. So it wasn't just clinical stuff.  
(Sean) You know, we were sharing methods and people would then use the method that you'd gained some experience in because you'd been talking about it, how you developed it and the problems, the challenges, the benefits.
- 17:17: *It sounds amazing.*  
(Jo)
- 17:18: And yeah, I think it's a really good example of how those teams can work and from a  
(Sean) learning capacity building, all that sort of stuff. I think it was really good.
- 17:26: *That's fab. So what was your PhD?*  
(Jo)
- 17:28: The aim of my PhD was to understand how MND multidisciplinary teams and people  
(Sean) with MND and their caregivers come together to make decisions about gastrostomy. That was my broad aim. One of the reasons I did that was because of my anecdotal experience and what was increasingly in the literature was that this decision, gastrostomy comes under so many different professionals' remits. So you'll have a dietitian monitoring the nutritional intake and worried about that; you'll have speech and language therapists monitoring their swallow; you'll have neurologists and MND nurses with a holistic sort of broad responsibility for care; you'll have respiratory consultants and nurses, and that influences the risks of gastrostomy placements. And you may even have palliative care who are doing some advanced care planning discussions with people. So you've got this one individual and they've got all these professionals who are in different settings, different organisations, having the same conversation.
- 18:23: And so there was a sense from the quality that that could be, if we're not joined up, people could be getting mixed messages, conflicting information, and that could create decisional conflicts which could delay decision making. And if we delay decision making, we delay starting interventions, and these are interventions which we think are associated with better outcomes. And so my focus was to truly understand how we're supporting people to make that decision.

18:49: We also knew that it isn't just, we're not robots, we're emotional beings and making decisions isn't just about being told you're not going to eat enough, you're gonna lose weight, that's not good for you, stick a tube in. That's not how people make decisions. As soon as you get told you're going to deteriorate in the future and you've got this option to have surgery, there's an emotional response to that information, and that emotional response can interact with how people then process information and make decisions.

19:16: So what I wanted to do is essentially to understand that it's a complex clinical problem occurring in with, I thought, this complex system of healthcare, this MDT healthcare. And I did that in three ways. I systematically reviewed the qualitative literature, I surveyed healthcare professionals' practice and beliefs around this. And then the main bit of work was I spent nine months in the field doing a multiple case study in three centres, actually watching the conversations happening, interviewing those involved, doing focus groups with the MDT, looking at what they were documenting, all around this decision to try and get these multiple perspectives of the same phenomenon and in real world practice.

19:56: And that was just an amazing experience. Again, anyone you say you've done a PhD, I think I was a stereotype. It was quite stressful. It was quite fun in the first bit where I was just doing lots of reading and developing ideas and then the really exciting bit of collecting data and then the really stressful bit of having to write it all up into a thesis and do your viva. So I think I was a stereotype, but it gave me a much, much deeper understanding of the influences of that decision that go well beyond the clinical outcomes, all the indicators for the intervention, and would inform how I would support - and did. So doing an IHR doctoral fellowship, I had one day a week clinical time as well, which you could invent a role for. So I went into the MND clinic, which they didn't have before, and I was supporting people to make decisions about gastrostomy. That was just my only role.

20:45: *Brilliant.*

(Jo)

20:46: And so throughout that whole year, I was reading papers, I was understanding the thing better, but I was always able every week to go in and tweak my approach to supporting people based on that understanding. And I thought that was just, it was so exciting to be able to, even if it's on an individual level, create research and immediately, probably the next week, think, oh wow, I should be speaking about this in this way and implementing it straight away.

21:11: *Yeah, that sounds great. And so you're saying now you're kind of at a point where you're trying to figure out what's next. Are you going to expand on your PhD and try and improve decision-making going forward? And how do you do that? How do you have that impact?*

(Jo)

21:26: Yeah, so absolutely, that's my... that's what I want to do. The PhD hasn't put me off wanting to still be a clinical academic, thankfully. What that route might look like is still very, very uncertain because of various reasons, but it's certainly what I want to do. My plan is to, I've got a few key things that my research has identified as things that we still don't really understand. And probably opportunities for decision support intervention developments in some way. So to make it easier for people to make

(Sean)

timely decisions, because timely decisions are important, but also make well-informed decisions, make decisions that are aligned with what matters most to them.

22:05: So absolutely, I've got ideas and I'm working those ideas up. Since I've come back, I'm really lucky. My care group in my Trust reinvest some of the research money that they get in to create a postdoctoral clinical academic fellowship. So it's one fellowship in my trust, four people who are finishing their PhDs. And we know again from the literature and personally that what can happen is people cannot have those opportunities. So they come out, want to progress, but there's just not the time. You can't do it as part of your clinical role. You need bridging of some sort, so it's another form of bridging. It's protected time, two days a week to develop my research ideas, put a proposal application together, as well as contribute to the local research strategy and initiatives.

22:48: And I guess as people do in the academic world, you have lots of fingers in lots of pies. So, you know, supporting others, so I've done a bit more mentoring and supervision of others now, people doing internships, supporting other people doing their research. So an example is a speech and language therapist in Australia who's basically taken my survey methods and my survey that I did. And is now repeating it adapted in the Australian context. And that was amazing to have someone come to you and say, can I use your, and I'll say yes straight away and know that what I researched is now happening in a different country, that's pretty cool. Yeah.

23:22: My absolute A plan is still to do my own primary research and be an independent researcher going forward and doing bigger, better, more impactful research as I go on.

23:21: *Yeah. That sounds brilliant. You've already mentioned a couple of positives from a personal point of view and the fact that when you were doing your PhD you were actually changing the way you were practicing. It was having an impact on that. What other benefits have you found being involved in research has had for you personally and professionally?*  
(Jo)

23:51: I've talked about how it's impacted on my care. I do think me being then saying these things to my MND team, I hope that's filtered through by osmosis for when people have those conversations. They may be thinking slightly differently about how they have those conversations. I think the benefits are presented and I'm publishing my research. And again, my absolute hope is that then triggers new research to happen. I think for my department, I've come back and I'm able to be a source of academic or clinical effectiveness expertise in some way and hopefully inspire, support others to be doing this type of work and thinking about these careers.  
(Sean)

24:31: I think one of the most important things about, I don't know if it's just academia or clinical academia, is the value of networking. So the value of picking up that phone, reading a paper, writing an email to the primary author and exploring what their interests are, exploring how they delivered the research or finding a healthcare professional's delivered a service wherever they are - Germany, Australia - it's amazing to do it on MS Teams all the time. But that networking, I have had so many opportunities from that, and I think that's one of the benefits of the time that I was allowed in the PhD to really go down that dark deep rabbit hole into thinking about this problem and having that time to meet people to go places. Like I went to Denmark for three weeks and spent time with people researching shared decision making out there.

- 25:17: And then, from the strategic point of view, I think it's developed my passion for then thinking about making that better for others - and for me, to be honest, it's a selfish thing that goes on. It's not all about others. I want to make the career path clearer for me as well. But because I was in that world, and now I've come into this role, and again part of that is a strategic focus, is that I think I've got a better understanding of what the challenges are on the ground.
- 25:42: I think the other benefit it's just confirmed that this is just such an essential part of what we should be doing. Not that I didn't think that anyway, but it just reconfirmed that we can't deliver good quality care without good quality research. And it's not just doing the research, it's how we then implement that into our practice and what's needed to make that happen. It's informed my ambition and my drive to think I still want to do this. I'm not finished yet.
- 26:06: *Yeah, yeah. And finally, if you have a colleague who is interested in research, what would be your top tip to them? What would you say?*  
(Jo)
- 26:15: My top tips would be, firstly, put it on your agenda with your manager. So if we're thinking maybe a junior AHP who wants to, but is getting no time to do anything, but really wants to, I would say first thing is in your annual appraisals, make sure that every time you go in there you tell them I want to be involved in research in some way. Keep banging on that door, so it's no surprise to them when you come to them next year and say, I want to apply for that internship.  
(Sean)
- 26:42: I think unfortunately, you've just got to say yes to a lot of things early doors. I think the reality of that is you take on a bit too much sometimes and you end up - this is bad to say - but you end up doing stuff in your own time. But I think just getting yourself connected with other people who are doing things. Say, who in your Trust is leading research which you might be interested in at the moment. There will be people. Get talking to them. Say "can I come and shadow some of your meetings? Can I get involved in what you're doing? Is there anything I can do?" Show an interest, showing that interest and willing, even if you haven't got the permission yet, that can come, but showing interest and willing to be involved will mean that you'll then be on their agenda.
- 27:22: But think wider as well. So if it's not in your Trust, who are the leaders in the area that you're interested in, and just reach out to them. Academics, as you've seen in the last hour, love talking about themselves. They absolutely love it, and I've never, I can't remember, I don't know if I can remember any time where I've approached somebody and they haven't said yes, we'll find some time to have a chat. And I think there's just so much value in that, in that it can create opportunities. Again, it puts you on their agenda.
- 27:51: The other thing that AHPs I think can do, which I got a lot of value out of, was joining sort of national specialist groups. So mine was the Parental and Enteral Nutrition Group of the British Dietetic Association. I joined as the home enteral feed clinical lead.
- 28:05: What that does is, again, it gives you some sort of more strategic leadership experience, and you get so much other stuff which is related to your academic skills, so you can organise study days, you can be involved in study days. You can maybe

access some funding and awards, maybe a little bit easier. And it just gives you that exposure on the national front. You are up to date with what the national agenda is in your area.

28:28: I think persistence beats resistance. So you will meet brick walls and just keep banging on it and eventually you just annoy people into letting you do things. You've just got to do that in probably a diplomatic... understand the other person's point of view, but still have your own agenda and stick to it. And be consistent. Don't give up, especially once you get into the academic world as well. You meet lots of pushbacks. Papers don't get published. You do presentations and they just felt that they went rubbish. You can't recruit people. There's lots and lots of knockbacks in the academic world, so you've got to develop a degree of resilience. And I think early on you've got to develop that resilience in that you will get told "no, you can't do this", probably for a period of time. But then with time, you hopefully you'll get a few more yeses.

29:15: So I think they're the main things really, from just those initial things that you can do as a jobbing AHP. One other thing I guess, just on what's current with me at the moment, is maybe making sure you have got a job plan. Medics are very good at job plans. AHPs not so good. And having a job plan which absolutely - it's in your job description or, if it isn't, it should be - that clinical effectiveness work and service development work is part of that job plan. It's something that you're expected to do. And so making sure it is and finding ways within your team structures to create time to do some of that work I think would be valuable because those early stages are really important.

29:54: And I'm going to say one more thing, and that's mentors are so important. I've got a few, and they're so valuable for me to be able to sound off against, to explore ideas with, not necessarily give me actual focused feedback about specific research projects, but just that general support a good mentor can give you is really valuable. And I think you can get those early doors. It could just be a senior member of your department who isn't your supervisor, but someone who you can go to and say, "how am I going to go about...?", so someone else that you can go to, I think is important.

30:26: *That's brilliant. Well, thank you so much, Sean. It's been a really enlightening conversation. I've really enjoyed listening to you, and hopefully you've inspired some people to think about it as a potential career option. So thanks again.*  
(Jo)

30:40: No problem, thanks for listening.

(Sean)

30:48: *That brings us to the end of this episode. A huge thank you to Sean for sharing his career story and the insights he has gained along the way. His journey illustrates how research can grow directly out of clinical experience and how it can be translated back into practice to improve patient care.*

31:07: *We heard how he progressed through an NIHR clinical academic pathway, obtaining a master's, a doctoral fellowship, a PhD and now having protected time for his research through a clinical research fellowship. He discussed the value of collaboration within multidisciplinary teams and the benefits of sharing experience and ideas with like-minded colleagues.*

31:32: *For anyone considering a clinical academic pathway, his advice is clear. Be persistent. Put your research plans on your manager's agenda. Seek out mentors and build your networks within and outwith your organisation.*

31:48: *Thank you for listening and I hope you will join me again for the next episode of Clinical Research Career Conversations. Until next time, bye.*