

Inspiring Doctors. Episode 13: Hannah Barham-Brown

Transcript generated by Adobe Premiere's AI and edited by Emma Green

Martin

Welcome to Inspiring Doctors, a podcast series brought to you by the British Medical Association. I'm Martin McKee, a professor of public health and the president of the BMA. In this series, I'm joined by people who I see as role models. They've successfully taken their medical knowledge to a wider audience in creative ways. So, what inspired their work? What lessons have they learned? And what advice do they have for young doctors who may want to follow in their footsteps?

There is something magical about the confluence of medicine and communication. My interviewees are only some of the role models who do this work. But they are all people who have inspired me. I hope that our conversations will in turn inspire you.

My guest today is Hannah Barham-Brown. After first training as a paediatric nurse, Hannah qualified as a doctor from St George's, University of London in 2016, and she's currently training as a GP in Leeds.

Hannah is a gender, disability and LGBTQ+ activist, a campaigner and an advocate who often speaks and consults on equality, diversity and inclusion. Hannah regularly works with national and local media, has given two TEDx talks and co-hosted the Salty Women podcast.

She's a former deputy leader and steering committee member of the UK Women's Equality Party, a governor of the Motability Foundation and an ambassador for the Design Council and for charities including the Eve Appeal, The Good Grief Trust and My AFK (My Action for Kids).

Due to her work on closing the gender pay gap in medicine, diversifying the medical profession and disability campaigning, she's been named as one of the *Health Service Journal's* 100 most influential people in health and named multiple times on the Shaw Trust's power lists, making her one of the 100 most influential disabled people in the UK. Welcome, Hannah.

Hannah

Hello. Thank you for having me.

Martin

Now, Hannah, your path to medicine has not been a conventional one. Before training as a doctor, you studied English, theology and Arabic, and completed paediatric nursing training. You were then diagnosed with Ehlers-Danlos syndrome while studying medicine. Could you tell us a little bit about why you chose to go into medicine and how your experiences influenced the way that you practise medicine now?

Hannah

So, as you say, it was quite an unconventional route. My original plan was that I was going to study English and theology with Arabic and become a war correspondent, which was going quite well until my mother told me, and I quote, 'You can't be a war correspondent, you'll get

shot and end up in a wheelchair.' The irony of that is now not lost as I spend a lot of my time in a wheelchair – I just don't have as good a story as I could have.

But yeah, I did my first degree and had that classic, what do you do with a BA in an arts subject? But around the same time, my youngest brother, Theo, who had been born during my finals, he had Down syndrome and spent the first 12 weeks of his life in intensive care.

One of my other brothers, Gareth, had had a heart transplant when he was 15. And so we'd spent as a family a lot of time in and out of healthcare settings, a lot of time in various hospitals around the country. And I think what really captured my imagination was not only the amazing life-saving care that my family received time and time again, but the truly holistic family-centred care we received at hospitals across the place.

Yes, there was Great Ormond Street and Addenbrooke's, but even the local hospitals, the care and the support that we all got – not just Gareth, not just Theo – really kind of inspired me to think, you know, medicine isn't just about doling out drugs and saving lives. There's so much more to it than that, and that holistic care is something I've really tried to take through.

And so, I think that's obviously influenced how I now practise medicine. I think I've learnt from my own experience and that of my family that medicine is just much easier, much more effective and much more uplifting as a professional when you do it in partnership with your patients. I think in a resource-scarce environment, the temptation is always to just get it done, get everything done, get the next person in, but actually, you end up then having to duplicate things and you have to have conversations over and over again.

As somebody who has a relatively rare condition, which has become a huge part of my life, and I have a family who have multiple very rare conditions that have shaped all of us – I'm acutely aware of the frustrations that you feel as a patient or as a loved one, of not feeling heard, of not feeling empowered.

And the futility of so much work that we do as healthcare professionals when we don't take that extra step to consider the more holistic nature, when we don't think about our patients in the round. And that's when in a resource-scarce environment, we end up doing things multiple times, explaining the same story over and over again.

So I hope that the experiences I've had do try and shape the care I provide, and the care that I support others to provide going forward. So I think that holism is kind of at the core of everything I do.

Martin

That's a really important point. I just want to emphasise that in case it gets lost. The point that you're making is of course there's a human, there's a moral argument for doctors engaging with their patients and co-creating the solutions to their problems. But there's also a simple efficiency or economic argument because if you don't, you get things wrong and you have to do them again and again until you eventually get them right.

I wonder if that point is made often enough, particularly when we look at the way in which we enable doctors to provide continuity of care, for example.

Hannah

Yeah, I think, you know, I see this in general practice all the time. It's very hard to have that continuity of care that many of us went into general practice for. You know, I went into GP thinking I loved the kind of cradle-to-grave, pre-cradle-to-post-grave care that we really give as a general practitioner. I love getting to know my patients and their families and the situations they live in and all of the other aspects of their life that can be impacting on the very specific condition they might have come see me about that day.

And I think when we lose that, which is what happens in the kind of pressurised system we're all working in, it's very hard to maintain that continuity of care. It's often one of the first things that goes. We lose so much more than that nice warm feeling inside of, 'oh, I really know my patients'. They lose that connection with us, but we also lose that kind of institutional but personal memory and that awareness, and as a result, it means more work.

I don't get the same person come in and I go, 'Right I know exactly what's going on with you, you don't have to start from the beginning. Let's just recap and think about where we are now.' You're having to do it all over again in every single appointment. And when you've got, what, on average seven minutes with the patient in front of you, that's not the most efficient way to work.

And I think if we can think about this from an economic perspective – let's face it, so much of our system and our politics at the moment is based on how can we get the most gain in the shortest amount of time. That's how. By letting us do what we're trained to do and what we want to do, which is to get to know our patients and care for them as individuals.

Martin

And by our failure to invest in health professionals, in equipment and IT and so on, we're actually creating a system that is inefficient by design. We actually need to invest in these things to be able to become more efficient. I'm not sure the politicians always get that.

Hannah

Most definitely. I mean, I'm currently living in this slightly weird land where I'm GP-ing half the time, but my father is currently going through some quite complex cancer treatment across multiple hospitals. And the number of times we've had to explain the whole story, like seven months of a lot of really complex stuff to yet another person because the notes aren't on the right system, and they can't see the notes from this hospital, and this hasn't made it across – it's so inefficient.

And I think if politicians could see what we see on a daily basis in that real, you know, hands-on way as opposed to a nice wander around a ward that's been freshly painted with their ties tucked in their shirts. If they actually understood what it was like on the ground to be a patient or to be a professional, then I really hope that that would make a difference. Because I think at the moment, they have absolutely no idea what it's really like.

Martin

I always remember a time many years ago when I was asked to undertake a review of the Chinese health reforms and myself and a colleague, a former Brazilian health minister, decided that rather than be shown around and presented with, obviously, things looking as good as possible, we actually said, 'We're going to role play and we're going to pretend to be patients. So, treat us as...' in his case a patient with diabetic retinopathy; in my case, acute appendicitis.

And we were wheeled through the hospital, of course, with all the cameras clicking and so on. But it was good to get a different perspective. That was maybe a very trivial example of what you're describing because we were only role playing.

But I want to talk about your many roles. You're a doctor, but you do an awful lot of other things. You've got a huge number of different roles, and this is something I can sympathise with a lot because I often find myself at meetings where I can be wearing maybe four or five different hats at the same meeting.

What do you see as the benefits of this portfolio career? And how do you decide what you do want to get involved in and what you say, 'Well, that's not for me'?

Hannah

I think when I started GP training, I felt like I was very much an anomaly in that being a portfolio GP trainee was not really a thing. But I had to be less than full-time clinically because my physical disabilities mean I can't work full-time. My body is just not going to be okay with that.

But as I've kind of progressed through and we've been through a pandemic and everything else that's been going on, to be completely blunt, if I wasn't physically disabled, I would still want to work less than full-time because if I didn't work less than full-time, I would have left medicine by now.

If I didn't have a portfolio career and other stuff, I don't think I'd have survived the last six years of being a doctor in the current system. And that's not for want of amazing trainers and colleagues, but it's, I think, very emblematic of the systems that we're working in now. And that's what we're seeing a lot. We're seeing so many junior doctors leaving the UK, so many leaving medicine, so many not training in the first place because of this.

I think medicine and being a doctor has been a huge part of my identity for the 13 years since I decided to apply for medical school. Having a portfolio career enables me to ensure that it isn't my entire identity, that I have other things outside of being a doctor, and it helps me stay in love with medicine. I actually really enjoy seeing patients and getting to know patients and feeling like I'm providing care.

But we have to acknowledge the huge moral injury that so many of us experience at the moment. Every single day I will see patients where I say, 'Look, I know what you need. I know who you need to see. I know which treatment you need, which examination you need, which investigation you need. And I know that you need it sooner rather than later. And I can't do

that for you. I can't get you this. I am likely going to be seeing you repeatedly for the next year whilst we try and manage your pain, whilst you're waiting for this.'

And doing that repeatedly day after day, the impact of that on you as an individual practitioner, it's brutal because we end up being the people who are constantly saying no, and that's not what I went into medicine for.

Martin

This concept of moral injury really only got traction during the pandemic. Many of our listeners will know, but maybe not all of them – it came from the military, the situation in a battlefield, whenever soldiers were unable to care for their colleagues.

It's the sense of frustration but it's much more than that – it's actually quite devastating when you know you can't deliver what's needed. I'm not sure that people outside medicine fully recognise just how traumatic it can be. What do you think?

Hannah

It is definitely traumatic. It's so hard because we use the NHS too. I think what people tend to forget is that everyone who works in the NHS is liable to use it. You know, we don't really have alternative A&E systems; the NHS is us, but also, we use it all the time. It's something that we need, and we rely on as human beings. Our families are in and out of it.

So, when we see it failing from the inside, when we see people being let down, that could be our mum, that could be our dad, that could be our child. And that's incredibly hard. And being that person who is always fronting it, who is always sitting there in front of somebody who is going through an incredibly traumatic or painful experience, whatever it is, and saying, 'I am so sorry, but I cannot do anything. There is nothing we as an NHS can do for you right now.'

Doing that over and over again – it breaks you. It tears you in two. And it's so heart-breaking because so many of us have put so much of our lives and our passion into getting where we are, into training as doctors. To have to say no all the time – it is pretty devastating.

Martin

Let's stick with saying no for a minute because you do have all these roles and you're very visible in the public eye, but you must get endless requests to do all sorts of things. I'm not sure if you've been asked to go on *Bake Off* or any of these other things, maybe you have. But how do you decide which ones you're going to agree to and which not?

Hannah

Yeah, I have had some strange TV requests which I've said no to. I'm still slightly disappointed I never did *Big Brother*, if I'm honest – that could have been hilarious. But also, I mean, firstly, I'm a woman with ADHD, so the second that a new shiny, exciting thing comes up, every part of me is sitting there going, yeah, that sounds great.

And learning to say no has been really difficult, partly because you feel like you're letting people down. I don't want to make people feel like they're not important and their opportunity isn't as great as all the other ones I'm offered.

But I think what I've really worked on recently is considering my overall priority. What do I want to achieve with my life and my career? And then every offer that comes in, I reflect back on how that's going to get me there.

So, for me, I want to make sure that the next generation of disabled people, of LGBTQ people, have it easier than we've had it. And I want to make sure that every single one of them looks up and goes, right, if she can achieve that, I'm going to be fine. I can do anything I want to.

And so, when I'm looking at the opportunities I'm given, I sit back and go, right, what is this doing to promote the cause of disabled, LGBTQ, women, whatever it might be. What is this doing to make change, and how am I going to use it? And if I can't find a really clear link between that and the opportunity, then I have to say no. But I really hate saying it.

Martin

Of course, that's why you're on this podcast, because you are a role model. But sticking with that, in your TED talks you've also talked about being a role model but in that, you're spelling it 'roll model' as a wheelchair user. And you've talked about the importance of representation among doctors to make patient care better.

Now, when we're talking about disability, we're talking about your situation in a wheelchair, but you're also a vocal advocate for LGBTQ+ representation. So, could you tell us more about how you see visibility in the medical profession? How do you see it making a difference, and how do you cope with this intersection between your different identities?

Hannah

So, I think it's incredibly important that doctors are perceived as humans. And I think for many, many thousands of years, arguably, there's been this kind of superhero narrative around medics of you have to know all the answers, you have to be able to work every day. You have to be saving lives every minute of every day.

And we still do this to an extent. You know, you go on a ward round as a medical student, you expect to get grilled and to be made a fool of if you don't know the answer. It's that kind of 'you must know the answer' attitude that can be really, really toxic. And I think when you have visible diversity in the profession, it helps change that. It helps take some of that pressure away.

People look at me and I've had, you know, very senior medics go, 'Well, of course you don't do cardiac arrests or anything like that. You don't hold the crash bleep.' When I was working in hospitals, I was like, 'I'm actually the first one there when the bleep goes off because I did wheelchair racing for years. I'm very fast.'

But people automatically make assumptions based on what they see and what they assume you're going to be able to do. And it's been really interesting being a doctor with a visible disability – the patients see that you get it. There's almost this unspoken awareness that you've probably been seen by a doctor yourself before.

You've probably spent some time on the other side of the stethoscope, and so you understand the anxiety and the lack of control that patients often feel they have. You can relate to that, and they see that. And I've had patients go, 'I know you get it, Doc, because you're broken like I am,' which always makes me ugly cry – but it's true.

And I think having that kind of visible difference and being very kind of vocal in your identities is so important because, you know, as part of the LGBTQ+ community, I am hyper-aware of the very real inequalities that we face, of the multiple ways in which we are frankly under attack from every front at the moment.

It seems that everywhere we go, some element of our community is being attacked or dissected. And it's exhausting, and it means that patients have very legitimate concerns that they're going to experience that at the hands of their healthcare professionals. And that means that they are less likely to seek healthcare when they initially need it. They are less likely to engage in preventative health measures as well.

So I think being very visibly out – my clinic room is covered in rainbows. I have, you know, posters trying to support. I have my pronoun badges on. I try and do as much as I can to show to people that I am a safe person, a safe doctor, that they can speak to who knows that whilst I might not always get it right, I'm really going to do my best to try. And I want to learn. And I think having that visibility is so important for patients.

It's also really important for colleagues. So, I have a medical student or a wannabe medical student get in contact with me probably at least once a week saying, 'I want to be a doctor but, you know, I'm a visibly disabled person. I'm a wheelchair user. I'm trans' – whatever it might be – 'can I do this? How do I do this?'

I've realised how little support there can be for different medical school applicants. So trying to be that very visible role model and bring those intersecting identities together, I think it does make a difference. I know it makes a difference because people tell me on a weekly basis.

But hopefully, it means that our patients start to look at us as human beings and go, 'You know what, it must be really hard to work in that system right now. I don't envy you, but I get it. How can we work together?' And frankly, how can we all come together to save the NHS? Because I think that's where we are right now.

Martin

Absolutely. Now, the idea that COVID-19 exposed the deep-seated health inequalities in our society is pretty well accepted by everybody now. So, I just wondered if you could talk a little bit about how that impacted on people with disabilities and particularly – something that's very much in the news at present – what you would like the COVID-19 inquiry to look at?

Hannah

Oh, I've got quite a shopping list for the COVID-19 inquiry. So, I found it really illuminating very early on in the pandemic when people kept referring to COVID as 'the great equaliser'. And I was like, no, you're getting this all completely wrong. COVID is the great illuminator. It is

shining a light on all of the inequalities that have been there for so long, but that we have just as a society, we've put our blinkers on and we've not wanted to acknowledge it.

I think we saw that so clearly when we looked at disability. So, you know, if we think about things like social care provision, which is obviously something very important to many disabled people, there were 125,000 social care vacancies before the pandemic even started. There are now over 160,000. I was working in care homes for the first six months of the pandemic, so I saw up close and personal how devastating those vacancies were and how much of an impact that had on the people who needed that care.

But I think also we saw so many horrific examples of discrimination throughout governmental policy and, yes, in healthcare. So, in June '21, a study came out from the ONS and the London School of Hygiene and Tropical Medicine, which looked at the disproportionate COVID deaths in disabled people.

That paper showed that in women with higher support needs, aged 30 to 69, so working-age women with higher support needs in terms of disability, they were 91% more likely to die than women of the same age without disabilities.

And that's after allowing for underlying healthcare conditions and their living conditions – so in terms of poverty, in terms of whether they lived in care homes or not. Once you'd taken out those factors, they were still 91% more likely to die. And when we look at disabled men, it was 74% more likely. That is not because they were disabled. We've taken out those factors.

So, one of the big areas we have to consider is discrimination in terms of what was actually provided for them. And we can see that there were so many examples of GPs sending out letters asking their disabled patients to consent to DNARs, there were patients who have muscular dystrophy being told that their trusts couldn't provide filters for their ventilators anymore, because they needed to be used for COVID patients.

All of these things were mounting up around us, and that didn't come from nowhere. That came from underlying inequalities and perceptions around disability that have been there since time immemorial. But it got so much worse when the pandemic hit.

And I think it's such an important thing that we need to consider when it comes to the COVID inquiry – thinking about, right, how do we do this differently? Because there's going to be another pandemic, there's going to be another major catastrophe at some point in the not-too-distant future, no doubt; touching all wood available that it doesn't.

But how do we address those inequalities now? What did we learn from that pandemic and how do we step back and go, right, this mustn't happen again; this disproportionate impact must not happen again.

So, I think there's a lot to kind of tease apart when it comes to disability, but there's a lot that we should have learned long before the pandemic hit. And I'm hoping we can see this inquiry as a kind of milestone where we go, right, we now know beyond doubt that there are huge inequalities in our society. What are we going to do to fix them now?

Martin

So, I've written a lot about what went wrong during the pandemic. But the common theme that comes out, looking at what happened in England, is that those who were making the decisions never actually spoke to the people who were affected by them.

And we can see that all the way through. We can see that schoolteachers, frontline health workers, local public health teams, procurement experts, laboratory scientists and so on and so forth were never actually engaged with. But I think what you've highlighted is that the disabled community were never spoken to either. Otherwise, these things would have become very, very clear.

Hannah

And it comes down to a lack of representation. We had next to no women around the table when the cabinet was making decisions. There were very, very few women who were at the highest levels making these decisions.

If you looked at the No 10 briefings, there were actual legal battles trying to get them to have a BSL interpreter at No 10 briefings. This really basic stuff just goes to show how little communication with marginalised groups mattered.

And then we sit there going, why was childcare such a disaster during the pandemic? Why were women more likely to have to quit their jobs? Oh, it's because nobody was thinking, who's going to look after all the children when the schools close?

And actually, if you'd had more representation around the table of people who actually came from these sectors, that could have been so different. But yet again, we had the same faces making decisions, completely oblivious to the wider needs of society.

Martin

And of course, one of the other guests in this series has been Jason Leitch, who was one of the people presenting at the Scottish briefings and they did have a BSL sign interpreter all the way through, so we can maybe see the difference there. But we might talk about the gender of the leading politicians, and that's another topic altogether.

So, this podcast is called *Inspiring Doctors*. What we're talking about here is you inspiring others with your ability to communicate to the public. But we do know that the word 'inspiring' is often used in ways that can come across as patronising to disabled people. This is something you have pointed out many times, so could you help us to understand a little bit more about that? How can we do better when it comes to avoiding or unlearning these stereotypes?

Hannah

So, yes, this is something I talk about quite widely. In the disabled community, we refer to something as 'inspiration porn', and it's where people come up to you completely out of the blue – and this happens quite a lot when you're visibly disabled – and go, 'Oh my goodness, you're just so inspiring to me. I honestly think you're amazing.'

And this can go further into, 'I just don't think I could live like that. You're so brave.' And it expands and it gets wider and wider, and it's so toxic. Because I might be sitting there in Sainsbury's trying to choose, you know, which brand of bread to get that week. And I'm just sitting there going, I'm not inspiring. I got up, I had a shower, hopefully. I pulled on some clothes and I popped down to the supermarket. I've just done it on wheels. That's the only difference here.

It's that constant othering. When you tell disabled people that they're inspiring, it others us. And it also puts on this really kind of superhuman pressure. We are not all Paralympians. I've had people assume I am a Paralympian, which is weird, because I'm really not very fit. But you get this kind of, 'Oh, you're so great, you're so wonderful.'

That means if you're being pretty mediocre... like I had some time out with burnout earlier in the year. And I found it so hard to try and balance my identity as this person who's constantly being told she's inspiring and does so well. When suddenly I wasn't able to – when suddenly the most I could do was put on clothes and have a shower and feed myself that day – that hit doubly hard, because I'd been told for so long that I was such a superhuman. My whole identity came into question, at a time when I was already struggling with my identity as a doctor who was experiencing burnout.

So, it can be a really damaging narrative, and I think it's one we really need to change. And in terms of how we do that and how we tackle these stereotypes, one of the big things is getting to know us. Disabled people make up 16 million in the UK. That's quite a few disabled people hanging around out there. And yet so much data shows us that people are scared to talk to us. I think almost the majority of people would not consider dating a disabled person, which is slightly disappointing, I'll be honest.

You know, all of these things are a constant reminder that people are scared. People are scared to get to know us. They're scared of saying the wrong thing. They're scared of insulting us. And as a result, they go the other way, and they don't want to even make eye contact when they roll past me in the street.

So we need to kind of think about how we have disability representation wider in society. Where are our disabled politicians? Less than 1% of our MPs are disabled. We have a few more in the House of Lords, but not many. You know, we don't see enough disabled people on TV who aren't being super-inspirational. I want to see mediocre disabled people, but we have to think about that representation more widely.

And also, we need to encourage this dialogue. So, a lot of the time there are some amazing influencers and disabled commentators out there writing books, popping up on social media, discussing important concepts that may have nothing to do with disability. And I think it's really important that we make an effort to find them and follow them and learn from them, and centre those voices and platform those voices because they're so often not heard.

And then something like COVID happens and shockingly we're not heard, and we lose out as a result. All of these things feed into each other and inspiration porn is, yeah, a very big part of that, unfortunately.

Martin

So, you mentioned that there are very few disabled people in the House of Commons. Yet, there have been some very important contributions made by people like Anne Begg and Jack Ashley, in particular in the past – something that Alastair Campbell has talked about recently.

But there's also been a big debate about how involved doctors should be with politics, a discussion that really became very salient during the COVID pandemic when some doctors, myself and others, were accused of getting into politics, and told we should maybe keep in our silos and stick to medicine.

Now you are a campaigner, but you've also worked in politics for years. You had your early experiences within the BMA, then you joined the Women's Equality Party and with them, you ran as a candidate for your local council, for the European Parliament, but then as police, fire and crime commissioner for North Yorkshire.

You were the first visibly disabled deputy leader of a national political party. You co-founded the party's disability caucus and you're now on the steering committee. So, do you think that more doctors should be involved in politics? And what do you say to those who do not believe that it could actually bring about any real change?

Hannah

I mean, I'm going to really shock you here, Martin. Yes, I do think more doctors should be involved in politics, without question, because, frankly, look at the shambles we have in health and social care right now.

I don't think anyone in health would be able to look me in the eye and honestly tell me that they don't think the situation would benefit from having somebody who actually knows how a health service works involved. It's that simple. I think as doctors, it feels like we're constantly being told by the Government that they know what's best, they know what's best for the NHS, they know how it will all work best.

And I find it deeply ironic as a disabled person because this is what I hear all the bloody time. 'We know what's best for you.' Pat on the head. 'Well done. You're very good. Don't use that wheelchair too much, your legs will get weak.' You know, all of this kind of stuff.

So yes, of course, we need more doctors in politics. And actually, when we have them, they do make a difference. So if you look at the work of Dr Rosena Allin-Khan, who is a Labour MP for Tooting, and she works in St George's A&E. I know because I've done shifts with her, and she still does those shifts because it's so important that she understands what it's like on the ground in the NHS.

And when you have those voices, they can feed into health policy. Now I am not saying that I approve of Labour's entire health policy. Clearly I do not. But I think it really shows when you

have people who get it in there. And we spend so much time as doctors going, the Government don't know what they're talking about. This politician doesn't know what they're talking about in terms of how we do health.

Okay, so go do it. Go and tell them; go and get involved. Because fundamentally, I am a doctor so I can advocate for and care for my patients. And I feel very strongly that politics is a very key area of that. I cannot look at myself in the mirror and say, I have done the best by my patients whilst I am watching the NHS fall apart and staying silent.

At the end of the day, I cannot sit there and go, 'ah yeah, but I shouldn't get my hands dirty, I shouldn't get involved in politics' and watch as the whole thing turns into a bigger bin fire, and not do anything about it. Morally, I think that's just so questionable. So yeah, I think we should all get more involved in politics.

Martin

And of course, there are other doctors in Parliament. I'm thinking of Dan Poulter on the Conservative side who is now on the backbenches. He worked as a doctor part-time as well, and he's been rather critical of his party's policies. So, I think we can see that having your feet on the ground in the NHS does actually allow you to see what's happening and bring it into the Palace of Westminster as well.

Hannah

Yeah. I guess something I've learned through my work with the Women's Equality Party and campaigning more widely is that being involved in politics doesn't mean contesting elections. You don't have to be sitting there trying to become an MP or prime minister or whatever. I would really struggle to be prime minister – there currently isn't a ramp into No 10 – but it's about trying to shift the focus of the conversations that we're having.

And I think as doctors with the title, with the privilege, with the position we have in society, people do tend to listen to us. And using that to try and push back, to try and platform and highlight issues – using that platform we have naturally as clinicians – is really powerful.

So if people are sitting there going, 'but I don't want to be an MP', that's fine, you don't have to be. But you can turn up on, I don't know, *Question Time* or your local MP's surgeries and clinics and say, 'So I'm a local doctor and...' – and pretty much anything you say after that, they will take it seriously, because of the power that comes with that role. I think as doctors, we have a really quite unique opportunity to try and push the dial politically and change the focus.

Martin

So, alongside your advocacy and your political work, you've been communicating and educating about medicine in many different ways. You've got a regular slot on BBC Radio Leeds giving out advice and you make use of social media to talk about medical issues, often bringing together the knowledge of a doctor and the lived experience of a patient. How do you find merging these different perspectives helps when it comes to educating others?

Hannah

So, living in the strange hinterland between being a doctor and a patient is quite a hard place to land, but you end up with quite a unique view from there. So, as I've said, I think the need to humanise medicine is more vital than ever and giving doctors a human face, I think is really important.

And we saw that during the pandemic, actually. We really saw people starting to appreciate the humanity of NHS workers. I'm thinking of things like the portraits of NHS staff by artists, all that kind of thing. But being able to say 'you know what, I get it, I'm a human being who gets sick too, and I need the health system too, and this matters to me too, and I appreciate how frustrating it is' can be so powerful.

But at the same time, I often find myself inhabiting this land where I've got very frustrated patients contacting me on social media, commenting on my posts, whatever it might be, saying, 'Oh yeah, but my GP's rubbish, I can never get an appointment. The receptionists are all mean' – all of this sort of stuff. And then I have doctors going, 'Patients don't get it. They don't know how much pressure we're under. It's really stressful.'

And none of that is a complete lie. That is the real experience of people on both sides of this, and we have to acknowledge those experiences, but we also have to kind of come together and go, right, no one side can fix this. It's only going to work if we kind of have proper dialogue between the two.

And so, I think being able to bridge that gap between doctor and patient is really important and showing that as a doctor, I know we don't get it right all the time and I think we have to accept that. But I think it's almost trained into us not to.

So, I think being able to display that kind of humility and say, sometimes we don't get it right. We're doctors, not robots, and that's a really good thing. I don't want to be treated by Siri – I'm now really worried my Siri's going to go off – but I want my doctors to understand the situation I'm in and I want my patients to understand the challenges that doctors face.

And so, living in between those two can be a very toxic and challenging place to be, but hopefully, it's somewhere I can really help make change.

Martin

And of course, you bring those perspectives together in one person. Not everybody can do that, but there are lots of other things that you can do. Certainly, in my work, we do a lot on co-creation. We've been looking at – most of my work is outside the UK – but looking at the pathways that people follow to get care for hypertension or trying to develop pathways for access to cervical screening among women who have a range of disadvantages.

And then you find the practical problems that people face, all the things that we tend to take for granted. You know, we're talking about self sampling and cervical screening, very good, but what happens if you can't actually post the samples back? But I could go on about that forever and I won't.

You once wrote that you, quote, ‘take pride in tackling topics people find difficult with humour and honesty, and encourage people to ask questions that they normally would shy away from in a public forum.’

So, do you find that there are commonalities between your medical practice and your campaigning work when it comes to having these difficult conversations? What tips do you have for people who are trying to communicate what some might think of as awkward topics?

Hannah

Yeah, there are huge commonalities. And I think my training as a doctor in challenging conversations and tackling challenging conversations has really empowered me as a campaigner because we have so many restrictions and barriers placed upon us by society of, ‘oh, you can’t say that word, you can’t talk about that thing in public, that’s a private thing’, that when it comes to accessing healthcare, we don’t have the language for it.

I’m thinking about things like, you know, I work with the Eve Appeal. We have a big project to try and get people to use the right names for their genitalia, using the word ‘vulva’ and ‘vagina’ correctly, because actually I have people come in and they sit there going, ‘Oh, well, doc, there’s a problem down there. Is that right?’ ‘There’s quite a lot going on down there. Can we be a bit more specific?’ ‘No, no.’

That makes life really challenging. It makes things more awkward, for them and for me, because you’re on this back foot almost. Having that knowledge, having that vocabulary is so important. And when it comes to, you know, tackling challenging conversations – my special interest areas are in sexual health and wellbeing, and I work in inner-city Leeds. So, I like to say it’s pretty hard to shock me. I like to think I’m pretty challenging to shock.

But I think it’s about acknowledging the awkward nature of this. It’s about, like, having a bit of fun with it and going, ‘You know what, people often find this quite difficult to talk about, and that’s totally normal. But also, this is stuff that I talk about a lot of the time. This is my normal.’

So, thinking about how we can signpost people in a, ‘I’m about to ask you some questions you might find a bit challenging, because people can find it awkward to talk about this stuff. I talk about this all the time, it’s the nature of my job, I’m not going to judge you. I have no interest in making you feel bad for whatever it is you do or don’t do with your body. I just want to make sure I’ve got all the information so that between us, we can get you all the support and help that you might need.’ That kind of signposting, but with reassurance, is really powerful.

Also, I work in Yorkshire. I love that up here we can be quite blunt. I like to practise what I call compassionate bluntness, where you can kind of douse it with a little slice of humour. You can sit there going, ‘Look pet, you’re going to have to tell me where it is. Like, what are we talking about? Do you want to draw a diagram?’ Actually having that really frank conversation can be quite useful, because I think if we as health professionals look awkward or seem uncomfortable, that transmits, that transfers to our patients.

It’s just about practising sometimes. The amount of awkward conversations I’ve had with my cats, in the run-up to actually seeing somebody, you wouldn’t believe. So I think that kind of

compassionate bluntness, signposting with reassurance and sometimes using humour, but also embracing the very natural human curiosity. People kind of want to know this stuff, but they don't necessarily feel comfortable talking about it.

And I think when it comes to how we use that in terms of campaigning – it comes back to that awkwardness people feel about talking about disability, about, you know, not saying the wrong words. So, I will sit there and go, 'Look, sometimes I can refer to myself as a "crip".' Other disabled people will hate that word, but it's a bit like the Tim Minchin song, 'Only a ginger can call another ginger "ginger".'

It's about acknowledging that there are linguistic challenges and that many of us reclaim language to empower ourselves. So, you know, some members of the black community will use the N-word in a way that is never appropriate for a white person to do. I will use the word 'crip' in a way that it is not appropriate for non-disabled persons to do.

But I think being able to take that language and have those conversations is really key. And when we shy away from those conversations, that's when things feel more awkward. That's when we're not being completely transparent and open, and it becomes very clear to people that we're not comfortable.

Martin

One of the things that really comes through in this series are all the different connections. You talk about discussing issues that people find challenging and I'm immediately thinking of the conversation I had with Guddi Singh, who took television viewers on a trip through the large intestine by virtue of virtual reality.

And I'll be talking to Alice Roberts, who's got a memorable clip on YouTube explaining the male genitalia using a bicycle pump and some tubing, but I'll leave her to talk about that particular one. But I think what we're seeing is lots of inventive ways of talking about things that people may not necessarily include in their conversations over the dinner table.

But I want to look at something you once said, which is that 'disabled people have to be problem solvers because the world is not designed with them in mind'. You're now an expert in this and an ambassador for the Design Council. Could you tell us about that role? Are there any examples you find particularly interesting of ways in which design can impact the NHS – doctors or patients?

I should preface this by saying that one of the things that I've worked on for many years is hospital design, partly because I've worked in so many hospitals which are so terribly badly designed. And my work in other European countries shows me that it is actually possible to design hospitals really well, that are actually patient-centred. But what's your experience?

Hannah

So, when I say that disabled people are nature's problem solvers, it's because if you look at the social model of disability which says that actually, I have an impairment, but it's society that disables me by being designed as if I as a wheelchair user do not exist.

I didn't put the stairs there, frankly. I didn't come up with stairs as a great concept. It's that that disables me. It's that that stops me from getting from A to Z. You know, if you want an example of this, as a disabled person, if I come down to London, I can access less than a third of the Tube system. And when I do, there's still a sizeable chance a lift will be broken, and I'll get stuck on it. It happened last week.

But I still have to get to places on time. I still have to, you know, crack on with my life and doing my job and everything I care about. And so, I've become very, very good at finding ways of solving problems, at finding alternative methods of getting from A to B. And when we look at things like design, a lot of it comes down to the fact that disabled people haven't necessarily been consulted through the process.

And we can think about that in an intersectional way as well. So, when I first got involved with the Design Council it was doing a project with Network Rail about the future of train stations. What I said was actually, when I get stuck, when I can't get a train or I'm delayed or whatever it is, as a wheelchair user – I have been assaulted, I've been grabbed, I've had my chair grabbed. I've had people try and sit on my lap. I've had all sorts of things happen to me late at night in train stations when trying to get home. Often drunken football fans, let's be honest.

And it's not just that I can't get onto a train or there isn't level boarding, it's that if there's a problem, there's nowhere safe for me to go. And when you then extrapolate that out to, as a woman travelling independently, the one place you've got for me is a dark corner that isn't up a flight of stairs – I'm not going to be safe there either, because I have a hypervigilance around gender-based violence, for obvious reasons.

So, you know, we need to think about these things from an intersectional perspective. I have turned up to sexual health clinics as a doctor, admittedly a few years ago in London, and found they were up two flights of stairs. What does that say about our attitudes towards disabled people and sex? Because to me it says disabled people don't have sex. To me it says: we've not thought that you might want this service, because why would you? And there are no disabled people involved in the designing.

So, if anyone is listening to this, I'm asking you very nicely to go into the disabled toilet of any NHS facility that you next go into. You don't need to use the toilet though; that's up to you. Go into the toilet and look at the bins. If there is a pedal bin in that disabled toilet, and no other bin, then I need you to go and speak to PALS or estates or whoever it is and get that bin changed. Because frankly, as a wheelchair user, if I could use a pedal bin, I wouldn't be needing to use that toilet.

But nobody disabled has ever been in there from a staff perspective and gone, 'I should probably let estates know about that.' Because people don't think. And it's not a lack of caring, it's a lack of experience and knowledge, that as disabled people we bring. So having those multiple voices around the table has a very tangible effect, because we make those things change.

Martin

This really comes back to this point that if we were doing this properly, we would be talking to the people who are using these facilities; we would learn. It's just so obvious when you think about it. But of course, if you're not in the situation of being disabled, maybe you don't think about it, but it's perfectly possible for someone who is disabled to contribute to that conversation.

Hannah

Yeah, I don't expect all healthcare professionals to be experts in every element of equality, diversity and inclusion. That would be unreasonable. I expect them to ask, and I expect them to actively be working to get more diversity in the profession, so they don't have to be the experts. It's that simple. If you have disabled people on the staff, they'll do this for you.

But we don't have representation in health and so as a result... it's not even about co-production necessarily, it's about literally having disabled staff. But there are some fantastic resources out there that people can use to learn more about health inequalities that we may face. So, when it comes to disability, things like Scope, Leonard Cheshire – they actually have helplines you can phone if you're not sure about an equalities issue. You can just phone them up and ask them, and they're very friendly.

And similarly, the LGBTQ community, things like GLADD, which is the Association of LGBTQ+ Doctors and Dentists in the UK. There's also the LGBT Foundation, which has got some great resources, and the RCGP has done a big kind of learning package which I think is available to all doctors, on LGBT health and trans health as well.

So, there are lots of really useful resources out there that people can access to learn more, but I don't think people necessarily know where they are to find them sometimes.

Martin

Now, years ago you told the *Student BMJ* that as a child you wanted to be 'a doctor, actress, detective, and a writer,' and that you hadn't ruled all of them out yet. Now you've recently begun to write a book, so could you tell us a little bit about that? How do you find it differs from the other ways of communicating that you're more accustomed to?

Hannah

So, I should start by saying it's very much in the early stages. It's kind of part memoir, but part disability rights manifesto for the 21st century. So, in each chapter, I'm looking at a different gap that disabled people fall through and interviewing disabled experts in that sector to go, 'Right, where are the challenges and how do we fix them?' to try and create a manifesto of what we need to do to create more equality, primarily in the UK, but in society more widely.

So, it's quite an interesting experience and I'm getting to interview some absolute heroes and heroines of mine. I'm having a wonderful time having great chats. How I get all of this into one book, I don't know. It may end up being, I don't know, a full-blown trilogy or something because I'm realising the more I talk to people that there are so many challenges I haven't experienced.

I had a really good chat with a journalist recently who was telling me how if you can't do shorthand, you can't get a lot of journalism qualifications. So, even though very few of them use shorthand anymore, if you have a physical or, you know, neurological condition, which means you can't do that, then that's you out as a journalist with this qualification.

So it's been really illuminating, and I'm finding that kind of long-form writing is quite different. I started out blogging, angrily, when I first got disabled, which really helped me kind of understand and develop my disabled identity, I guess. And going back to that kind of longer-form writing, stepping away from the 280-character limit on Twitter, I'm finding it fascinating.

But it also feels incredibly daunting. So, I'm really hoping I get a very lovely agent and editor soon who can either hold me back or push me forwards as required.

Martin

Well, quite a few of the people who've been on these podcasts have actually written books, so I'm hoping that at some time it would be nice to get you all together and you could compare notes on that.

Finally, I'd like to close with a few personal questions that I've been asking everybody. We're talking about doctors as role models. So, who are the ones that have inspired or are still inspiring you and why?

Hannah

It's quite difficult when you've been a doctor for, you know, any more than about 10 minutes because there are loads of them! And it's really hard not to name them all.

So, the ones that immediately come to mind – when I did my first ever day on the wards as a paediatric nursing student, I was put in a neuro-oncology clinic and the doctor didn't turn up for the first 10 minutes and I was starting to panic. I was like, oh great, my first day on the job, I've lost the doctor; this does not bode well.

And I went out, and I found him sat in the kid's area around a colouring table, a giant man with his knees around his ears, colouring in, talking to this four-year-old girl. And this guy was a guy called Simon Bailey, who is a paediatric neuro-oncologist in Newcastle, who I'm sure does not remember me at all.

I remember going up to him and going, 'Oh, I'm really sorry, your clinic's actually started. We're in that room over there.' And he said, 'Oh no, I know it's started, I've started it.' He explained that actually, he was watching how this girl was colouring in, what her mobility was like, what her dexterity was like, what her co-ordination was like, how she was speaking, and he was assessing her as he was sitting there with his knees around his ears, colouring in. And I think that was the moment I went, 'yep, medicine is awesome, and I want to do that'. That comes back to that holism thing.

And I think the other person who is still inspiring me hugely today is Professor Chloe Orkin, who is president of the Medical Women's Federation and a prominent member of the LGBTQ community, specialising in HIV. She's also really passionate about mentoring but also

sponsoring younger doctors. And she's been a huge support to me as I've been sitting there going, 'What am I doing with my life?'

And she's also spoken really out and proud about being a disabled female leader, which is just so reassuring, that there are more of us out there. And it's so fantastic to see people at all levels of their careers kind of talking about this stuff, because that didn't really happen when I joined medical school. So, it's really good to see progress there.

Martin

Well, I hope they're able to listen to this podcast and hear how much they're appreciated. My very last question: what advice would you give to someone who's just graduated in medicine and who would like to follow in your footsteps?

Hannah

I suppose my first piece of advice would be don't try and follow in anyone's footsteps. Medicine is a fantastic, diverse, and exciting career, and I think if I'd tried to do it the way anyone else had, I probably wouldn't have had as much fun.

I've said yes to a lot of opportunities. I am learning to say no to others. But I think it's really important to find where you want to be, who you want to be, and what your actual priority is, as not only a doctor but as a member of society, as somebody who is kind of almost automatically thrust into a leadership role in society.

People still hold doctors in really high regard in society, whether or not it feels like that. And so, I think it's important to really take that seriously and consider your privilege. Consider the privilege that comes with having the word 'doctor' in front of your name, and yeah, treating that with the gravitas that it deserves, because it gets you into rooms that other people struggle to access.

So I think having an awareness of that, having an awareness of your privilege. But also grasping opportunities that come, and being aware of where each one is taking you. Don't try and have too much of a plan. I haven't, and it's gone quite well so far! But yeah, I think don't try and mould yourself into the shape of any other doctor, any other clinician. There's space for all of us, and there needs to be if we're going to make progress going forwards.

Martin

Well, speaking purely personally, I couldn't agree more. Hannah Barham-Brown, thank you very much indeed.

Hannah

Thanks so much for having me.

This podcast is hosted by Martin McKee, produced and edited by Alex Cauvi. For more information visit bma.org.uk/inspiringdoctors