Inspiring Doctors. Episode 15: Stephen McGann and Heidi Thomas

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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.

This episode is different from the others in this series. I've been talking to doctors and one dentist, but this time I'm talking to two people and the doctor who is the subject of today's podcast doesn't have an actual medical degree. Rather, he's an actor who portrays one on television and who in doing so represents what is, at least for me, everything that is good about medicine.

He is the kind of doctor that I would want to have caring for me and my community. Indeed, a doctor who portrays the qualities that I saw in my parents – general practitioners who devoted their lives to a community on the sectarian interface in Belfast, despite the challenges of 30 years of inter-communal violence. Qualities that my brother who took over for them also showed.

So today I'm joined by Stephen McGann, known to many as Dr Patrick Turner in the BBC series *Call the Midwife*, but also an experienced science communicator with a master's in science communication from Imperial College – and also by the creator of the series, the accomplished screenwriter and playwright Heidi Thomas. And I should point out that in real life, Steve and Heidi are married to each other.

But before we start our conversation, I suppose it's just about possible that some of our listeners are unfamiliar with *Call the Midwife*. It's a television programme set in the East End of London in one of the poorest communities in the country. A religious order provides midwifery care to the local population, which changes over the progress of the series with successive waves of immigration.

Some, but not all, of the midwives are nuns, and Dr Turner is the local GP. The programmes tackled what were – and in some cases still are – very challenging issues, including racism, poverty, homelessness and of course, sex.

It's been suggested that it does for midwives what James Herriot's *All Creatures Great and Small* did for vets. And for me, it is a fantastic resource for showing the social determinants of health in action. Welcome, Steve and Heidi.

Stephen
Hello.

Heidi
Hello, Martin.

Martin
There is so much that we could talk about given the wealth of material that you've provided us with. You're now filming the 13th season of a series that has provided a history of healthcare throughout the 1950s and 1960s. But let me start with each of you in turn.

Steve, as I've mentioned, you have a degree in science communication. It's not an obvious career choice for someone whose early screen credits include many of the classic British soaps like *Juliet Bravo*, *Brookside* and *Emmerdale*. Why did you decide to do it and what did you get from it?

Stephen
Oh… first part of it first. The best way to answer that question is to go to a very, very brief potted history of what happened to my education. I began to be an actor at 19 years old. I walked into a wonderful business. I had lots of interests as a child. I was quite a sickly child and funny, this will come back, but I spent a lot of my childhood in the kind of hospitals you see on *Call the Midwife*.

But I dreamed of space. I was part of the Apollo generation. I just beat the generation who began to do computer science, and I loved computers. I used to love watching mission control on the Apollo missions.

But I later developed an interest in drama. I flunked out of my A-levels, and then I became an actor at 19. Had great success throughout the ’80s and ’90s, and I've been an actor for 40 years now.

But when I reached my 40s, a lot of the things that drove me were unfinished business for me. The education – things I felt I'd missed. I didn't go to university, and I missed that. And I wanted to go back and re-examine those things and my curiosities in other directions.

I'd always had an interest at school in physics and in science. So long story short, I went back. I studied for a computer science degree. When I got that, by the time I’d finished that part-time study, when I was still an actor, I'd become very, very interested in the wider social aspects of the interface between science and society.

So, when I graduated, I very timidly – and I was already an established actor by this time, I was in my mid-40s, my early 40s – I walked timidly into Imperial College and said, ‘Would you have me? Could I come and do a brick-and-mortar master's degree in the field of science communication?’ And they were fantastic.

If anybody doesn't know what science communication as a field is really about – it's the most enormous umbrella field of study which covers the philosophy of science, science history, the

relationship between science and society, science media, journalism. So it covers an enormous range. And actually, those wonderful people at Imperial College said, 'You know, you have been communicating all your life because as an actor you communicate. Many people come to our discipline with the science side of science communication, with the first word. So, what we find quite cool is you're coming with the second word, as an expert in communication, but coming back to science.'

But I had the most fantastic, life-changing time then. And while I was studying, a certain little thing called *Call the Midwife* happened, quite by accident. I was working part-time during the first two series of *Call the Midwife*.

I was a student for series one and two, and afterwards I decided not to do a PhD and instead, I would speak on the issues of science and medicine in society, in my rather strange role now as not simply somebody interested in those things academically, but someone who was playing one of those TV doctors at the very interface of wider mass communication.

Martin
Now we're going to be talking quite a bit about your alter ego, Dr Turner, but you've used your science communication skills in other ways. Can you tell us something about them?

Stephen
My science communication skills now… so I reached a sort of fork in the road. I could have gone further into these questions. What my real interest in science was – I'd seen so many commercials and adverts as a sick child. My own family had been saved, essentially – the long social history of my family, about which I wrote a memoir.

Basically, my family's story was we only subsisted as a poor working-class family until the late 1940s when the welfare state basically lifted us. And medicine was a really important part of that.

So, I was actually interested in the way that science interfaces with society because it affected me and people like me very, very personally and directly. My family is only where it is now because of medicine. And literally, I am *alive* because of medicine. My wife, Heidi, is alive because of medicine. So, the NHS has a very direct effect on our outcomes.

What was interesting to me about it was I'd been playing characters facing out to the bigger public. Now, when you study science communication, there's a guy called Stephen Hilgartner who came up with a very, very famous theory about the way we communicate scientific and medical things in society. And he talked about upstream and downstream communication.

When you study science communication, you often talk in these terms and debate them endlessly. But I quickly realised that the working-class guy I was, the way science had impacted me when I was a kid was very much what Stephen was calling the downstream type of communication – the communication with mass media.

I'm an estuary guy. Now, sometimes if you're a great scientist speaking in some very august university in a back room, you're very upstream. If you give a scientific article to *The Guardian*,

that's still quite upstream. But here I am, going out every Sunday night, to sometimes seven and a half million people plus.

If you are six feet away from somebody, and you are able to communicate the fact that maybe vaccination is very, very important for your family – in a dramatic way, meaning an experiential way where you look at outcomes in a human and a Stanislavskian process of consequences if things don't happen – with that immediacy, that closely to that many million people, that's a very, very powerful tool.

So I had a foot in these different camps, and I've since been delighted to give talks, to try and share my curiosity and my enthusiasm and my discoveries from being someone who is able to walk from discussing those more academic sides of science communication to someone who is at that communicative interface, where I know that the things I'm doing in work have been shown to dramatically affect… for instance, one very tiny story:

The next day, after one particular episode of *Call the Midwife* where we covered diphtheria, the NHS got in touch with us and said they were inundated by people immediately looking for their webpage on the NHS website. So many thousands of people suddenly looking for good, high-quality information for things that they believed they wanted to know that could affect their family or their children.

It was the public behaving with common sense in response to drama that was properly communicating the idea of social health outcomes for people. So, I'm aware of all these things. And when you say, well, how does it affect me and what's my motivation – this is what motivates me to speak with such enthusiasm now.

Martin
I think you've just explained so well why I felt it was so important that we had the two of you on this series – it's an incredible contribution.

One last question just before we move to Heidi. You recently tweeted about the importance of the humanities. And given your twin roles as an actor and a science communicator, that might not seem surprising. But maybe you could develop that point in a little bit more detail than you had space for in your tweet.

Stephen
Thank you for the opportunity. I've been tweeting for a long time and sometimes it's very difficult to get over, shall we say, the nuance of certain realities of the world.

So, why am I wanging on about the humanities so much? Well, the 21st century faces absolutely huge challenges for us all. Climate, shifting geopolitical power towards a more multipolar world, gross inequality, instability, pandemic disease, the proliferation of dangerous weapons, changed working practices – you know, the onset of AI and people's insecurity about the approach of new tech.

All those things, when you think about them, the solution to all those challenges rests on our ability to collectively understand ourselves – where we've been in the past, who we are and

where we would like to go and how we might achieve that together. Those are all humanities skills.

Now I speak as somebody who has an MSc and a BSc. I am a STEM guy too, as well as an actor. So I don't believe, and I don't think anybody in science or medicine really believes what the old CP Snow said about the two cultures being separate. We debate it endlessly, but I don't think anybody really believes that's the case.

So I'm a STEM guy who believes that actually, STEM has done great things for the 21st century already. In a way, STEM and sciences homework is already well ahead of the humanities. For instance, you know, people in environmental sciences have been telling us accurately for years about their work, telling us that anthropogenic climate change is real.

Are we listening? I don't think so. But they've been doing that for years. And of course, great Professor Gilbert and her COVID-19 developments were the result of years and years of brilliant research. So, you could say in a sense that science is well on top of the 21st century.

But what we really need to attend to is the humanities side of those things, because as many scientists will rightly recognise, it won't get listened to. The science side will be wasted if we don't all understand the wider social impacts.

And it's just the wrong time for me, for anybody involved in public policy and education to be saying, 'Let's defund it, who needs humanities? It's airy-fairy people popping about doing useless subjects. But what we all need to do is make you all very, very narrow, get you a very tight set of STEM abilities so you can go to a nice job.'

I don't think that's the answer. And I feel very, very strongly, as do many of my scientific colleagues, and people I greatly admire, that it's not the answer to our problems. And as any good scientist will tell you, these things are a symbiosis. A good scientist tends to be a polymath. Every great scientist I've ever met has been a wonderful polymath.

Great doctors are polymaths, and they understand it works in symbiosis. And the only way to solve our problems is if, in a sense, humanities catches up with science. And the way you don't do that is to close down the doors for people being educated in wider humanities education.

Martin
Well, I think you've summarised the message that we want to convey in this series of podcasts – the bringing together of science and communication and the humanities. Just listening to you, I'm reflecting on a major report that I wrote for WHO about two years ago on the future of health and sustainable development in light of the pandemic, setting out the threats to health that you've just mentioned. And I'm beginning to wish I'd just asked you to write it for me because I think you would have done it extremely eloquently.

But, Heidi, your earlier writing experiences might also seem a bit removed from *Call the Midwife*. But again, I wonder if there are some connections. You adapted Ibsen's play *The Lady from the Sea*, which also featured a doctor.

And at this point, I might mention that I also use one of Ibsen's other medical characters, Dr Stockmann from *An Enemy of the People,* in my teaching. He's an example of someone who is willing to speak truth to power – a bit perhaps like Dr Turner.

And then there was *Upstairs Downstairs* about the class divisions that characterise English society. Did any of these experiences prepare you for *Call the Midwife*?

Heidi
It's a really interesting question, actually, Martin. I don't think anything could prepare me for *Call the Midwife,* and also *Call the Midwife* itself has evolved over the now 13 years of its incarnation. So, there's always been something that I don't know or something new that I need to learn or find out about.

So, the sheer scale of it and the stories we've been able to tell about 20th-century working class, 20th-century women, 20th-century medicine, have grown organically over that period of time.

I think if I look back, like Steve, I had a childhood where I spent a great deal of time in hospitals. I was actually quite robust, but I had a younger brother who was born with Down syndrome and tetralogy of Fallot at a time when that was inoperable, and his life expectancy was extremely short. So David, my brother, was in and out of hospital. And I loved the world, and I loved the work.

And I actually passionately wanted to be a nurse, but received no encouragement. I went to a very academic all-girls grammar school where you were expected to go to university. And at that time – I was doing my A-levels in 1979 – nursing was not a degree-level subject. So when I went to the headmistress and said I wanted to be a nurse, she was rather dismissive and she said, 'Oh, you're far too clever to be a nurse.'

And I said, 'Well, I'll be a doctor.' And she said, 'You're not clever enough to be a doctor.' And that was my medical career. I sort of fell very neatly between two stools.

I must stress that I refute the fact that I was too clever to be a nurse. I was probably just about clever enough. Nursing is such an extraordinary profession and I still feel as though I've missed something, if I'm honest. A really fulfilling, intriguing life path where I would have been able – you know, if I'd practised as a nurse over the past 40 years – to have really kept abreast with developments in medicine and surgery.

Anyway, that remained my private passion. The only medical thing I wrote in the early part of my career was one episode *Dr Finlay's Casebook* in the David Rintoul years. But I was able to choose and research my own story, and I wrote about a vaginal fistula in a woman who'd given birth during the First World War, you know, at home with an untrained midwife. So that was a little precursor, maybe, of something that was to come later.

In the early 2000s and broadcast in 2007, I did a series called *Cranford* starring all the dames, Judi Dench, Eileen Atkins, they were all there – a wonderful literary opportunity. It was called *Cranford*, but it wasn't just based on Elizabeth Gaskell's novel *Cranford*, which obviously is a

classic, but I amalgamated into the storytelling mix some of her short novellas and short stories that were also set in the fictional world of *Cranford,* albeit known by other names.

And there was a lengthy short story, barely even a novella, called *Mr Harrison's Confession*. It was the story of a young man with some surgical training who comes to a remote Cheshire village in the 1840s and meets with a couple of quite interesting medical cases, one of which I was able to identify through my reading and research as a Pott's fracture of the wrist. And I was thinking, well, how would he do this?

I thought about the role that ice must have played in the Napoleonic Wars in the treatment of battlefield wounds, because war always pushes medicine on. And I found this concept really intrigued me, and still does, just in terms of my own personal reading and my awareness of what's gone on, for example in prosthetic limb development since the Gulf Wars.

But I was very fortunate to be offered as a medical advisor on *Cranford* – when I realised medicine was going to be woven into the plot in a much more detailed way than I'd originally envisaged – the services of a fantastic GP called Martin Scurr, whom you may know of. He has a column, I think in the *Daily Mail*, although I don't think he did have at that time, so he was a stranger to me.

But he said the most wonderful thing. I said, 'I want to do this operation. I think this young doctor would pack the wound in ice,' – quite revolutionary at the time. I said, 'How would he operate?' And Martin said to me, 'A surgeon must have light.'

And I didn't know that. The idea that a doctor would know something so true and so simple and so profound then connected in my mind to a motif that runs throughout *Cranford*, which is the ladies of the village are extremely parsimonious about candle use. They will only burn one candle at a time.

And so, I was able to create a story – not in the original novel – where all the ladies bring their prized candles to the young doctor, and give him 50 candles so he can perform this surgery. I loved writing it. I also showed him treating a feverish patient with belladonna, and I worked out the dosage myself from an old almanac.

My grandfather was a herbalist, a medical herbalist who trained on the job in the 1890s and 1910s prior to conventional medicine being available to very poor communities. He lived in a Dockland area of Liverpool. So I went and worked out what this character would do with his belladonna to cure a fever, and Martin Scurr said, 'That's spot on. What an interesting method.'

Anyway, post-*Cranford*, I was really looking for another literary adaptation to do because I love Victorian literature, and I was approached with Jennifer Worth's memoirs, and I took one look at the cover which had scruffy urchins on it and said, 'No, I'm looking for Victorian literature.' I read 17 pages of that memoir and I realised that what I really wanted to do was another medical drama.

There was a brilliant, visceral description of a woman giving birth in unmedicated circumstances in about 1957 to her fourth baby. So no complications were expected, and none occurred. But I just loved what the book had to say about the role of the medical caregiver and how the big physical events of our lives, be they medical – even crisis-related, such as the need for surgery or a big accident – or something natural and potentially perfectly straightforward, such as childbirth, really shape our lives and our sense of ourselves.

And I think between *Cranford* and *Call the Midwife*, I found my niche, if you will, or possibly my life's calling, as a writer of medical drama.

Martin
And in fact, Steve has written about how when you were reading through the book and you were getting lots of books for possible adaptation at that time, you said, and I quote, 'You know, I think I might be able to do something with this.'

Heidi
Yes, and 13 years later here we are. It was an extraordinary privilege to be offered a memoir rather than a fictional piece, or indeed a factual piece, because there's something about memoir – when people bring their own perspective and their own experience to the telling of the story, you get something which, certainly for me as a reader, is always that little bit more visceral and that little bit more engaging.

And Jennifer Worth, who wrote the original trilogy of memoirs, *Call the Midwife*, did not sit down to write her story until she was 71 or 72. And the book wasn't widely promoted originally. The only thing she'd written previously was a little book, little more than a pamphlet on how she cured her own eczema through diet. And it was the same publisher who took on *Call the Midwife*.

But it gained momentum through the circuit of reading clubs, word of mouth amongst women, and it became quite a big hit. So, for me, the challenge was to honour the spirit and the passion and if you like, the purity of Jennifer's memories, but turning them into something that had dramatic rigour, and also a degree of scientific rigour that I've worked on and hopefully continue to burnish to the present day.

Martin
So, you had an added challenge in what you were doing. You were dealing with the memoirs of someone who was still alive at the time that you were beginning the process. So, what challenges did that pose?

Heidi
I'd never adapted the work of a living author beforehand and I feared far more pitfalls than there proved to be. Jennifer was a very quick study, and she lived not far from me in Hemel Hempstead, so we developed a relationship where I would drive over to see her and we would chat over lunch. One day, nothing much happened at all about *Call the Midwife*; she just played the piano for me. She was a very skilled pianist.

We got to know each other and there was mutual respect. I deeply respected her because of what she'd achieved with the memoir, and she respected me because of my skill, I think, as a craftswoman. After I showed her the first draft of the first episode, she had a very minor note about some small point of detail about where a cake had been hidden. I'd hidden it in a different place for reasons I can't now remember, and she pulled me up on that.

But she said, 'I think you know exactly what you're doing and I'm happy for you to do it. Come back to me if ever you need any content or advice.'

And very sadly – although she gave me a lot of handwritten notes and quite general memories about the East End, nothing specifically to do with midwifery, interestingly – very sadly, we were about to start filming and she was diagnosed with cancer, and passed away very quickly before we even started filming.

I was so grateful to have had that relationship with her and indeed that friendship with her. I was very fond of her, because I think she set me up to do what I later did. What Jennifer did was – she was only in the East End for six months, she only did her midwifery part twos there because her ambition was to become a hospital matron, and you had to have midwifery qualifications to do that in those days, in the 1950s.

She actually had a desire to work in palliative care, when that was very new. So once she'd qualified as a midwife, she didn't go back. And because she passed away when she did, I was very much on my own, but felt I understood her way of working. And I did what she did – she used to go to Hemel Hempstead Library and research things, and I went online a lot more.

By the time we got to series two, which was going to be eight episodes plus a Christmas special, we had – not exhausted the material in the memoirs, but we had used about 75% of the usable relevant material. And I realised that the secret was to move away from midwifery and into general practice medicine.

We'd already seen Dr Turner, although he was a very minor character in the first episode, but when I found out that GPs were also obstetricians at that time and were able to run their own little self-directed, very autonomous maternity homes, I thought that was a golden opportunity. So, it did expand Dr Turner's role.

I also looked at ways in which the East End was changing; waves of immigration, bringing in different populations with different disease susceptibilities, hand-in-hand with the rise of vaccination.

Every series, I sit down, I think of Jennifer, and I think of her books. But my first and principal point of reference are the Medical Officer of Health reports for Poplar and later Tower Hamlets, which are stored online at the Wellcome Trust. And I read the statistics and I read the narrative reports, which are richer in some years than others.

But I never thought I would find statistics moving or inspiring because I'm dyscalculic, I've never been a numbers person. I'm a 'left, right – no, the other right' sort of person. And yet

reading these statistics, which are so dry and so plainly set out, you start to see the history of a people.

To begin with, the statistics denote the number of venous ulcers in legs, enormous numbers of venous ulcers, which to me indicated undiagnosed diabetes. Five years later you're looking at greatly reduced venous ulcer cases, and a massive uptick in diagnosed diabetes, which of course is now being treated.

And in 1957, polio was still active. At the beginning of series two, we're rolling out the vaccine. By series nine or 10, there are no cases of polio in Poplar, and that actually moves me to tears. The number of times I will shudder when I look at statistics and how things are changing, what's now being offered to ordinary people.

Also by the mid- to late ’60s, how health education is becoming important as well, sex education – you know, educating people about sex, because now you can do something about its more negative consequences. You can treat what was then called venereal disease with various antibiotics. You can provide married women with the pill. Brook Street Clinic was doing great work providing unmarried women with the pill, and we have referenced that as well.

And yet there are never fewer problems for me to write about or fewer challenges, just different ones. And that I find genuinely exciting, as part of my brief to tell stories which are emotionally engaging and feature people from many walks of life.

Martin
Actually, that story reminds me of something my wife wrote many years ago when she went back to the annual reports of the Medical Officers of Health in Limerick, and related them to the accounts of living in Limerick written by Frank McCourt in *Angela's Ashes*.

Heidi
Oh wow.

Martin
And he'd been challenged at the time because people were saying, ‘Well, it actually wasn't as bad as that.’ But what he was describing was borne out perfectly in those reports. So, I think this juxtaposition can be very powerful.

There's an amazing book about the first decade of the series, and I can highly recommend it to everybody. But one of the quotations from there, I quote, is, ‘The woman's world of childbirth had spent too many years in the shadow of TV drama while the mothers endured lives of invisibility, indifference, pain and shame with incredible stoicism.’

Now Lord Reith, who founded the BBC, said that its duty was to inform, educate and entertain. So how do you balance these three principles in *Call the Midwife* to inform, educate and entertain?

Heidi

I think I balance it by standing in the shoes of my characters, in the shoes of the people I am writing about. And I feel that I approached the world of the women and the working class and the disabled with a degree of respect that is not always applied in other dramas on television. I feel the respect and the love that I have for these people make the stories emotionally engaging. If they engage me, they will engage the viewer and thereby it becomes entertainment.

But I wasn't prepared to make the nuns – who are principal caregivers and skilled medical professionals as well – I wasn't prepared to make them objects of ridicule or prejudice. So, for me, it starts with respect. It progresses into emotional engagement and if you like people, you will naturally find them funny and that evolves into a sort of comedy. And again, that's entertainment. So that's the entertainment part of it.

In terms of inform and educate, there's a sort of Venn diagram, I think, for inform and educate that overlaps very, very strongly. And I think I approach those two things as illumination – shine a light on things that aren't having a light shone on them from any other direction. And that might be something as obvious as women's bodies.

I think one of my favourite episodes was series five, episode one, where we have a lady who suffers from stress incontinence after having given birth to eight or nine children. And she doesn't know the word ‘vagina’ and Dr Turner, when she is eventually guided towards his services, says, ‘All you had to do in order to alleviate the problem was ask.’ And she says, ‘I didn't have the words, did I?’

So sometimes through my characters, the audience is given words to deal with things. And that also happens in not necessarily specifically medical things. I think about the work we do with infant loss. Sometimes it's not about providing the vocabulary, it's providing the permission to talk about things.

Every time we feature infant loss within the context of the ’50s and ’60s, I personally – and I don't know why they write to me personally, it might be because I'm a woman, they don't write to the actors about it, and I don't think they even write to Steve about it – but women and sometimes men will write to me and say, ‘I lost a baby in 1964. I wasn't allowed to talk about it. I wasn't allowed to bury the child or have any record of it.’

So again, that's about illuminating experience through fictional characters who feel very real and identifiable to the people who are watching. Just with regard to the educate thing, we have quite a strict policy of research back-up and research inspection, I would call it. I do my own research initially; I go to the Wellcome Trust, for example. I read very widely. I go through the British Newspaper Archive to see which stories were topical during any given year.

But when I've drafted the story roughly, and certainly before I've completed a first draft script, we have midwifery advisers on tap and GP advisers on tap. But if, for example, I'm doing a story about tuberculosis or burns or porphyria, which crops up in the next series, my script team will go and find me the correct advisers who are experts in their field, and we might only work with them for one episode.

And we always work with two, because we feel it's important to have two differing points of view. We feel that gives us more scientific integrity. And of those two, one of them will always get what drama is about and the other may not get it at all, or understand that we have to write from a historic perspective. So, we cover our bases that way.

Stephen
If I could add something about the nature of expertise as well, which I think is something Heidi achieves particularly well on the programme. Expertise, and especially if you've studied science communication, you talk about the nature of scientific authority and expertise a lot, issues of accuracy come up.

But if you're considering certain social crossovers to medical issues – we'll use Down syndrome as an example. What our show also seeks to do is gain expertise not simply on the medical aspects. A pure medic might be able to tell you about the chromosomal nature of Down syndrome or Fallot's tetralogy, but what about the names that that child was called in those days? What about the parents' access to education?

And so therefore, when we gain expertise, we also go to communities of interest at a very, very early stage in script production and we get their input as well. And this has been vital for us over the years not simply to cover bases, but to understand expertise in its much wider societal sense, because we have to tell a story beyond the simply procedural.

Martin
Wearing another hat, I've been doing quite a lot of work in looking at what we call co-production, co-creation. And there we've learnt that it's so important to engage with the people that are affected by the decisions, who can then become part of developing the clinical pathways.

We did a large trial where we were looking at simplified management of high blood pressure in Colombia and Malaysia. We spent a year developing the interventions with the communities, poorer communities in both countries, and we got great results.

And I think this point about listening and engaging is really crucial. But I think you've also really encapsulated well what I often say is my role in public health, which is to make the invisible, visible. And I think that's something that you do remarkably well.

I'm going to come back to Steve in a minute, but before I do, one question for you, Heidi. I understand that you only tell Steve about the scripts at the same time as the rest of the cast. So it's as much of a surprise for him as everybody else. Is that really true?

Heidi
It's totally true. Honestly, I tell you, there are good reasons for it. One, I don't want Steve to feel – ironically – disadvantaged, when he's with his fellow cast members, because he's having to keep secrets or they might be suspicious that he knows something about their character trajectory. He can legitimately say, 'I know nothing, I know nothing.'

But the other thing that happens – not least because of medical considerations, as I've explained to you – often the medical storylines are revised as we go along, we might change or drop a scene. You can tell an actor, any actor, far too soon about what is going to occur to their role. We don't show actors very early drafts of scripts because if you then cut a scene because it's too long or it doesn't work medically, they'll say, 'Oh but I liked that scene, where I did such and such.' Sorry, I did a whiny voice for actors then!

But no, seriously, I wouldn't want to expose Steve to a script at an early stage because he might either be tempted to start learning lines which would then change, or the story itself would then alter. So, I just think it's much fairer to have a totally level playing field. And also no arguments – when he gets that script, it's finished, and I take no notes. There is no discussion about what Dr Turner is going to do.

Martin
So, a recipe for marital harmony there.

Heidi
We never have a cross word.

Stephen
No, we don't, dear.

Martin
Steve, as someone who helped out in my own parents' general practice in the late 1960s in a very similar setting to Poplar, where the series is set, I've really felt that you've captured the role remarkably accurately. So how do you do it? Did you talk to doctors who were working at the time? Did you shadow doctors that are working today? What's the method that you used to capture their lives so accurately?

Stephen
That's such a great question. The honest answer to that is no, I didn't go shadowing modern-day doctors, for instance, who might have a worldview which is different anyway. It was all there in the text. I'm one of those old luvvies who believes a lot of what you need to see is already there when the writer finally gets me to see it.

But the really important thing about it for me… I was asked this question by, I think you know Dr Kamran Abbasi. When he was at the *Journal of the Royal Society of Medicine* some years ago, he invited me to write a guest piece on really this broad question; what was happening, what did I think about it? I think the really fascinating thing with playing Dr Turner and the task I have is related to the relationship between accuracy, which professionals of all types are always looking for in drama, and a wider sense of something I call authenticity of performance.

And they relate to each other. The accuracy of what you're doing procedurally as a doctor is very important. My experience, when the script finally comes to me for someone like Dr Turner, and from the beginning – it's been looked at very carefully by medical teams. When I get onto a set, I have a wonderful collection of medical experts and staff who are able if I, for

instance, was needing to do a particular medical procedure, they could advise me how to do that. That is essential. It's very helpful to me.

And if I were to go away as an actor and ask ‘Dr Google’ or someone else and go off nowadays in 2023, I’d probably cause more harm than actually listening to someone who's looked at the context for the ’60s, who knows what they're talking about, who've been able to learn how to work a particular piece of equipment, how to handle a particular implement. They are the best people to listen to for that. That's the accuracy part.

But a really interesting thing happens. In a sense, I get assistance for *that*. Those things come in and act as an actual role. If you want to know how to jump out of a plane, you take certain advice. When it’s left to you, the real work of an actor starts. When all of the procedural stuff is ready and done. Because what an actor is really there to do is to fill out the human. Once you’re given that accuracy – absolutely essential as a core – the authenticity part of it sits over the accuracy and is much, much bigger and wider.

So what you're trying to do is encapsulate a human being in the National Health Service, in that place and time. Turner isn't all doctors from 1957 to 1969. He's this particular widow who served in the Second World War, was actually shell shocked and damaged in the Second World War. And a lot of his approach to mental health is informed by his very personal past.

So, he is a doctor. He is like other doctors that might have existed at the time. But his trajectory and biography veer away into his own world. And that's where the world of an actor really comes into play. How is he a particular instance of a doctor from the ’60s? How is this particular type of doctor, in this space and time, meant to react to the situations he comes and sees?

And my favourite responses from medics, who I've chatted with all over the years… A couple of responses – the first one came from wonderful John and David Suchet, the actor and the DJ and presenter and newscaster. John approached me one day in a bar and he actually said, ‘I hope you don't mind me coming up to you, but I just wanted to say how much me and my family love *Call the Midwife.’* I was very flattered.

He said, ‘Now, it's not to do with all the normal things. It's to do with the fact that we watched my dad as a GP going out in the morning, and going and working hard. And he worked once in the East End, and we remembered him coming home, tired. We remembered who he was and how he was, and it brings back so many memories for me.’

The other time, and one of my favourite moments, was when a GP came to me and said, ‘Look, we know the accuracy thing. We know if you're doing that right or wrong, that's all fine. We can see that you do that. But you know what I really love? You look scared, and you look tired sometimes, and sometimes you don't know what to do.’

And I found that so moving because it was so human. And they say, ‘We love to see a representation of someone who can be kind from a place of vulnerability.’ Who is trying to deal with the heavy workload he has in a human sense. That's where my real part comes in.

That's where *I* tell that part of the story. The people that bring the procedural side have already done their brilliant work.

My part is to portray that, but *Call the Midwife* is not a sequence of procedural stories. A documentary can do that better. You know, *24 hours in A&E* can do that better. That's not what our drama is there to do. And that's what I think is so valuable about being able to sit and approach the idea of a GP in the National Health Service at that crucial time.

Martin
I want to come back to some of those points later, but one question that I know a lot of listeners will be very interested in is how you deal with the technical aspects of doing this. Now, I know that actors often have body doubles, but I read in your book that on occasions what we thought were your hands, Steve, when they were holding a baby, were actually those of the husband of your midwifery adviser, Terri Coates, who by good fortune is a paediatrician.

But the birth scenes are incredibly realistic. I'm not sure if it's like being a member of the Magic Circle, but are you allowed to share with us some of the ways in which you managed to present those births and some of the other things you do?

Stephen
I can't tell you how proud I am of the way the camera work and the technical aspects have had to evolve over the years. We were making this stuff up. It was ground-breaking when we really took cameras into the room. So let me go into the background of that before we get into what we do technically, which I've been doing this week, in fact.

When we started, what was a birth on TV or in film? It was a well-made-up woman with beautiful bouffant hair, gasping, likely for two minutes, and then out pops a baby. And not all the time – to be fair to everybody – but most of the time, Hollywood and films just didn't dwell on such things. It was, apart from anything else, the misogyny that meant it was a closed women's world that frankly didn't interest a lot of people in the filmmaking business.

We came along and literally blew the door open into that delivery room. So just like documentaries were doing at that time, we did something for drama. But there was a problem. It's before the watershed at 9pm, and for people who don't know – this is another credit to Heidi – at 10.30pm on Channel 4 or whatever, you can show nowadays pretty much what you like. You can say what you like, swear how you like – you can do anything you like.

But on a mass-watched television programme, on a peak-time Sunday night TV drama, which is considered before the 9pm threshold when children are still awake, the constraints on you are even more particular. And what you have to do is tell some very, very indelicate medical stories for a whole family.

So, therefore, we had this technical problem. How have we got around it? I'll get to the hands in a second, but I was amazed when we first began to film it the way the camera people, the directors were solving those problems, shooting through the legs; how you show, for instance, blood. We're not allowed to show too much blood – Heidi can expand on that.

But the pre-watershed and BBC guideline rules mean that there are some quite ironic rules about what we're allowed to show of women's blood compared to what we're allowed to show of murder blood – you know, blood resulting from murders in drama, compared to a completely natural childbirth. But that's another subject.

We're not allowed to – obviously we don't – use real blood, but we've evolved. Mixtures of fruit juices, and other mixes. And often when the waters break, I was doing it last week, that, would you believe – I'm telling you some of the secrets – is a condom filled with a sort of diluted fruit juice and some other mixtures mixed by the make-up team, which you then pierce and the water comes wonderfully.

There is this ridiculous scene in our close-knit TV set where the props guy is holding a large, very sort of expanded condom full of this stuff. That's one thing. We use real babies, of course, but we use different model babies as well, for different sequences at different distances. We're very clever, the way we swap those things in and out.

We shoot through the legs in a particular way. If you think of the human side, the female actors who come in and play these brilliant roles, it's a very exposing business. And so a lot of what we do also when we're trying to work out these smart camera angles, these cutaways, we are very, very conscious of a guest actor who might be in an environment where it's quite intimidating – they have their legs up in stirrups, for heaven's sake.

So the pastoral care we give, the women responsible and many of the women responsible for running our production… We are very proud of the security and the sort of pastoral nature of the support that people get on set, so people feel comfortable and able to do their best work.

In the particular stuff, say forceps. The way I work with my hands, the detailed clamping of an umbilicus, of the cutting. We've had to learn those tricks over the years. We're better at them than we used to be. But a lot of the time that actually is my hands.

The real help we were given was mostly during the pandemic when we weren't allowed by pandemic rules, if we were to continue to film, we weren't allowed to handle babies for a pretty good reason. And often there'd be a kind of – if you remember the old series *Thunderbirds* – there'd be a kind of a cutaway where somebody else's hands, often the parents of the actual baby or else a medic would take hold of that baby, because we weren't allowed.

I'm very soppy with babies, everybody on set knows that. There's nothing I love more than having babies there. So, when I couldn't hold a baby for two years, I was absolutely bereft. And now I can hold babies again, which is lovely. But all of those little details, we work very closely on. Those scenes are very long and hard and technical, but we're very, very proud of them.

We had a good guest actor in last week and we're very proud that when they get to the end of that process, they say, 'This has been amazing. You've all been really great, really supportive.' And in our small way, we like to think that we're doing the medical business proud by actually showing this thing in a way that's also compassionate. That's also something a whole family can sit down and watch.

And I'll finish on this point, which is that we do some quite medically hair-raising stuff. When children or daughters are watching with their mothers, when young boys are watching with their fathers, when whole families are sitting together and they are able after the programme's finished to go and discuss some quite interesting things, often with social consequences. If you take, you know, abortions, if you take different tragic elements of medical consequences. They are able to go off and talk about them.

So, to communicate those compassionately, in a way that's not too graphic that it can't get through to the screen – but in a graphic enough way that we're not sparing the realities of certain things from whole British families in 2023 – I think that's a wonderful achievement.

Martin
Incredible.

Heidi, I want to ask you about one of the issues that you dealt with in the series, the thalidomide scandal. And you've already told us about how you were going through the newspaper archives and all of the other sources at the time and were becoming, effectively, a historian.

But you wrote about how you were shocked when you read the correspondence between the thalidomide community and the Government. In fact, you said that you looked into the bag that you had put this correspondence into and wondered why the bag didn't just burst into flames. Can you tell us a little bit more about your experiences working with those who were affected by the scandal and how that experience in turn affected you?

Heidi
The interesting thing for me about thalidomide was it wasn't something I found out about or had to be told about because I'm exactly the same age as the thalidomide survivors. I was born in 1962. So there are some thalidomide-affected people who are a little older than myself, some a little younger – not many, it has to be said. I would have come at the tail end of it.

As a child, especially because I had a disabled sibling, I spent much of my childhood and adolescence pushing my younger brother in his wheelchair through parks or along the seaside. And every so often I would see another child or adolescent pushing a sibling in a wheelchair, and that sibling might be completely lacking arms and legs, and it was thalidomide.

Thalidomide was not only very visible in the ’60s and ’70s – you know, as it should be, disabled people should always be visible – not only visible but in people of exactly my own age. It was something that affected my peers and therefore it was something that always interested me, and it was something I always cared about.

When it became obvious that *Call the Midwife* was going to run for more than two or three years, I realised that if we got as far as series five, that would lead us to December 1961, when the whistleblowing letter was first published in *The Lancet*, written by an Australian domestic obstetrician, very like a Dr Turner character, who ran a little maternity home who had noticed the correlation between Distaval and limb anomalies, and indeed drastic anomalies, and stillbirth in some babies.

So, I had to hold fire and we did get to series five and as soon as we started preparing, I said, ‘This is the thalidomide series.’ Interestingly, in the three or four years we'd been making the series already, we'd developed technically what we could show in terms of anomaly surgery and limb difference. We'd already done spina bifida using CGI and medical prosthetics.

So we felt, although it was a challenge, this was a challenge we could meet. And I said to the team, my wonderful producer Annie Tricklebank and Stella O'Farrell, who does our makeup and special effects, I said, ‘We are going to do the best work of our lives.’ And I have never been more impressed by my fellow professionals than I was when we tackled that story.

But as Steve has already mentioned, we always reach out to any community who is affected by the stories we're telling. That might be the Down syndrome community as Steve has specified. In this case, we reached out to the thalidomide community, which is strong and has a long campaigning history of its own, which still is active and live because these people have not had necessarily the support that they deserved and merited. Everything has had to be fought for, initially by their parents, more latterly by the community themselves.

So, there's a Thalidomide Trust and a Thalidomide Society, and they overlap and conjoin, but not necessarily in ways that as an outsider one would fully understand or expect. We approached one branch of the thalidomide community and then were contacted by another who said very robustly, ‘Nothing about us without us; we're coming to your office.’

We were petrified! And in actual fact, really fruitful discussions ensued. One of the things I love about the thalidomide community – whom I have got to know quite well in recent years and I count a number of thalidomide survivors as good personal friends as well – is the way they look out for each other. Thalidomide touched people from many different social classes and there's a real level of health inequality in there that's interesting to excavate.

Just as in the present day, the National Down Syndrome Policy Group that Steve and I work with exists because parents who have – whether it's education, time on their hands, or influence – in greater quantities than other people, perhaps, who lack the confidence to take the Government to task or lack the confidence to launch research and support projects.

The three people who came to our offices from the thalidomide community were highly educated, very motivated, very seasoned campaigners, and they were dealing with the Government and industry at the very highest level to get justice for themselves and their fellow survivors.

None of them were particularly severely affected but they were affected in their upper limbs. And having got our attention and having been assured that we would absolutely listen to them and make sure their story was portrayed accurately, they started to give me documents to read.

And why I was surprised the bag didn't burst into flames was what has gone on is incendiary, and it remains incendiary. People being rebuffed, people being lied to, things being concealed. Even, and something that Steve and I both felt very proud to ultimately be a part of, an

unwillingness within Government to put up a memorial for thalidomide survivors and their families. And I found that profoundly distressing on the simplest, most human level.

And a year or so after *Call the Midwife* first featured the condition and the scandal, let's call it a scandal, space was found within Cathays Park in Cardiff for a beautiful granite memorial to the whole thalidomide community of the British Isles, and I think worldwide – there was an implication that it memorialises everybody worldwide.

And we were told that it was the raising of the profile of thalidomide and the damage it did that enabled this to come to pass. I think that's just a lovely example of the soft power of something like a television series, it's attempts to tell stories respectfully, truthfully and with love.

Martin
An incredibly moving story, thank you so much.

And Steve, your account of how you dealt with abortion at a time when it was illegal, it's incredibly traumatic. You describe your feelings as Jeanie, a mother of two, dies in an ambulance after a botched abortion. Now, as we speak, there are women in many parts of the world who lack access to abortions. And in the United States, things are going backwards. Can you tell us more about how your experience of filming those scenes has shaped your views?

Stephen
I am, I mean, I may sound like a biased person. I am in awe of my partner, Heidi, and her ability to bring all the different nuances to what is – whatever one's feelings – a complex and difficult issue. What strikes me with abortion is, however you approach it, whatever your beliefs are, it's not something that is, quote, 'easy'. It's not an easy answer. People come upon this condition usually in conditions of distress. Their lives are not, you know, they don't skip into this condition. It's not an easy thing; it's never been an easy thing.

From the very beginning in *Call the Midwife*, we've taken not just a clear-eyed view of women's position as regards the state of illegal abortion – because it was illegal until the end of the '60s – but the reality for women and with the country with the status quo at that time of abortion being illegal, and women then seeking it in places which were certainly medically inadvisable and very harmful.

It was beautifully shown with devastating effect for the first time on *Call the Midwife* in series two. The part that you talk about came much later when we had, I think it was in series eight, a multi-episodic look at the very many different debates around abortion in the mid- to late '60s, working up towards the Abortion Act and the Abortion Bill.

It obviously was so difficult. But at the time I wanted to go back, and I did go back and do some research because as I was going through these storylines, I wanted to know back in the newspaper archives what the contemporary feeling was.

One of our problems with the worldwide – you might call it, reception context, to abortion is they're culturally very different where *Call the Midwife* is shown right across the globe.

Somebody in the Midwest of the United States of America will have a whole different cultural reception context to abortion than someone in Great Britain, for instance.

I wanted to go back and look at where we were in the mid-'60s when this debate that led to the Abortion Bill in England and Wales really came to a head. And there are great Hansard meetings in the House of Lords debate, there are great Hansard details and data where you can go back and listen in a sense to the conversations people were having. There are newspaper articles where you see the outcome.

What overwhelms you when you go back there is, people were overrun with the mutilation of women at the time. It wasn't a debate back then of pro-life and pro-choice – that hadn't been invented, that came much later. It was this very old law, which was producing women, most of whom had multiple children – they were married and often they would be in poverty, and many, many of them had multiple children already. They would try to seek an abortion because they literally felt they couldn't go on with another pregnancy, when they didn't have access to good birth control at the time.

And they would end up being pitched outside the casualty departments of Britain's hospitals. Even the expense, the cost, as they discuss in these contemporary newspapers, the cost to the NHS was absolutely enormous. Even if you get rid of all the moral – the many good moral questions – for a moment, people were arguing even in the financial sense, this is a ridiculous situation.

But things really began to change in the mid-'60s when everyone, I think, in the establishment was surprised by an opinion poll which came out, I think it was in the *Mirror,* where a huge amount of the public voted for change.

What's interesting with echoes to modern things, it's like the public reminding those in power that actually the outside things had shifted, and people were requiring something to be done to change these things. And it was then when the politicians and the Lords and the clerics within the Lords began to debate very honestly the state they were in and try to do something about it. Only very much later when it became a law, other oppositional movements started to organise, as happens in a democracy.

But back then, for me as an actor playing those things – me and the nuns we're working with in the East End are dealing with the consequences of this law. You are dealing not with the higher-blown moralities, you are dealing with the raw, nasty consequences of the fact that this thing will always happen, and that what should happen is that it should be done medically and safely. There needs to be a pragmatic and a medical solution.

I end my thoughts on that with the thoughts of Jennifer Worth herself, who famously wrote – she was a woman of faith and whatever her personal reservations were, she was very clear about her experience and what she thought about the need for, you know, clinically-governed and safe abortion. She said, 'Women will always seek abortions. It is a medical issue.'

And I believe at the end of the day, whatever one's feelings about these things, it is a medical issue. It is a medical issue, and it needs to be handled safely. And underneath that is a very

fundamental, almost philosophical thing about the way we're all governed. Sometimes I'm more proud of Government when it does things when they are very hard, and it does things for the greater good when it's not so nice or simple – it doesn't feel good.

Nobody gets a warm, fuzzy feeling from legislation, one way or the other with this issue. But what I believe: by medicalising this issue, it's not cute or warm or fuzzy, but it's right. It's the right thing to do. And that's when Government is at its most effective and its most mature.

Martin
Heidi, I wonder if I could ask you just to reflect on the situation worldwide. We're looking at the United States, with individual states rolling back the legislation after the repeal of Roe v Wade. This must be very difficult to watch.

Heidi
It is very difficult to watch. And I feel a degree of personal connection to it, not just as a woman, but because of *Call the Midwife*. When these laws first started to be rolled back, my personal email post box and our social media channels of communication were filled with messages that I personally received from young girls asking if they could use clips from *Call the Midwife* on their Instagram pages to show their peers and the lawmakers what the likely consequence was going to be of this, you know, removal of the right to abortion.

I found that absolutely heart-breaking because obviously, I've plotted the move towards the legalisation of abortion in the United Kingdom very carefully, in dramatic terms, in historic terms, and we were as accurate as we could possibly be. And they were some of the most upsetting scenes I ever wrote. Kitchen table abortion. Attempts to self-terminate pregnancy.

And to think that young girls, in a modern society, in the present day, are looking at a drama set 60 years ago and thinking 'that could be me' is harrowing. In what way is that progress? For women or society as a whole?

Martin
Question for you both. There are several issues that you include in the series that challenge our sense of the nature of medicine. I'm thinking of how early in the series you include some quite negative representations of what was a very hierarchical hospital where a surgeon is not being challenged on bad decisions and where the doctors are really being quite dismissive of the skills and experience of the nurses.

And then in season four, Dr Turner suffers from something akin to burnout or maybe moral injury, when covering for colleagues. He has such a high caseload that he misses a diagnosis as a result. I'm wondering to what extent you've had feedback, praise or criticism, from doctors about the representation of the profession on the screen.

Stephen
It's not been terribly negative if I'm honest. People understand that the NHS and the people working within it – Dr Turner's personal enthusiasms aside – was always a work in progress. It had terrible growing pains. It's such a large bureaucracy as well. It would always have tensions

within it. In a sense when telling this story, people often accused us of rose-coloured spectacles.

Of course, we never – you're right to point that out – we've never been like that. The NHS has always had problems somewhere. It's always been trying to adjust something. Things have been argued even before its creation. And we tried to show that Dr Turner's a huge enthusiast. He's a great advocate, but he doesn't always get his way. And as we go on in this series, there's greater and greater medicalisation, the NHS has evolved into something.

I think one of the most useful things we've been able to show more widely about the nature of medicine is how we might have got to here. One of the great things about *Call the Midwife* is that it's a historical drama, but it's very recent history. It's living history for many. It's living history for me now. I remember that NHS now, as a child.

And the great thing is it's just close enough where people and even young people can look up women's rights, can look up the nature and the running of the NHS system. They can get an idea of why people made the decisions – mass vaccination, X-ray machines. Why people did the things they did back then.

It's been particularly effective actually during the pandemic and with vaccination. I'm a great advocate for vaccination, personally and in communication. And it's been a great help to go back to the doctors working back then, to try and give people context, to say, 'Just see – when all those things were around back then, you didn't have to tell my mother to have a measles vaccination, because she'd seen the effects.'

We haven't seen the effects of certain things. So, in the same way, the NHS, it's nice to kind of show it sometimes warts and all. To say, 'Look, it's in trouble, it's in crisis now, but this is why we decided to do the things we did and maybe we can all come together. We think it's worth preserving, but we should all be involved in the discussion for why we do that.'

Looking at doctors red in tooth and claw, one little side issue for Turner, it's worth mentioning – accuracy is funny when you talk to GPs. I remember one interchange where they said, oh, you need to show this, you must show that. I said to this GP, humorously, 'I'm not a wedding DJ. We don't do requests. You can't just take communication by command.'

And one guy said, 'Oh, look, but it's bad that you're smoking.' And of course, anyone watching the series knows that Turner smoked. And I don't smoke myself. What's peculiar is it was a drama decision. I don't smoke; it's a disgusting thing. And by series five we got rid of the smoking, the smoking was gone. But it was a wonderful thing when we began, to quickly take the viewer right back, to show them silently that this was a different time and place when even very intelligent, medical people thought differently, in a different world. So it helps people understand that.

But this guy said, 'Well, no, you need not to do it.' So basically, I mentioned that landmark, I think it was a 1961 study, where they used GPs – you know, it's real landmark stuff, and I said, 'So, you know, this comes out of that study. Lots of GPs were smoking. So basically you're saying you want us to be accurate, but not that accurate?'

We won't always do everything completely by the book. We will show certain things and it won't always be flattering to a 2023 head. We will always try and show those.

Martin
Yeah, that was Richard Doll and Austin Bradford Hill's study of British doctors.

Stephen
That's right.

Heidi
The feedback we get is very interesting because obviously, the drama is… we move a year through time with every series that we do. So the series is always set 50, 60 years ago.

One of the things that keeps the drama going is midwifery in particular. Well, all medicine changes, but midwifery changed quite dramatically in the ’60s with the shift towards hospital births. And yet the feedback… and I think this is probably because we've always had excellent advisers such as Terri Coates, who qualified in the early ’80s, so she was taught as a midwife by women who'd been practising in the ’40s and ’50s – you know, it was a long historic reach.

Quite often, present-day midwives praise us for depicting the softer skills of midwifery. Yes, absolutely, our midwives can deliver shoulder dystocia, breech deliveries – most common by caesarean now. But midwives will stop me at a conference or some sort of event and say, ‘It's so wonderful how you show midwives using grounding techniques when they're consoling a woman who's in labour, for example reminding her, you know, “you've got a lovely husband and soon you're going to meet your baby” when she's going through transitions and is very panicky.’ That is now considered to be almost innovative and modern.

And what I love is that classic midwifery, the kind of skills Nurse Crane shows because she's been delivering babies since before the Second World War, are now seen as desirable attributes and things that need to be delivered through training to modern midwives who are often, or most often, delivering babies in hospital. So I love that we're often praised for affirming midwifery techniques.

That means a great deal to me. And it is to do with the softer elements of midwifery and therefore trying to depict things through the medium of characters. And I like to think that we show how things can be done, without necessarily hospital transfer or heavy medical intervention. It’s about the humanity of these deeply necessary skills and about the reach of ourselves as people within a system that can sometimes feel quite mechanised.

Martin
That's really such an important message. Now we're getting to the end and I'm going to ask you both the same questions that I've asked everyone else on this series of podcasts. For the first one, I'd like you to put yourself into the character of Dr Turner and ask you what advice you would give to a young doctor who was seeking to emulate him today?

Heidi

One of the interesting things is in the last couple of series, young Timothy Turner, who's Dr Turner's son, who's been with the show since he was nine, is now in Edinburgh at medical school, and he's starting to help out in the surgery, testing urine and weighing babies and that kind of thing.

And I do find it rather lovely for me to stand in Dr Turner's shoes and give advice to young Timothy. You're actually seeing that happen on screen. And I would say something I'm thinking of perhaps putting in a future series, is Dr Turner telling his son that the patient will never forget this moment.

I think the thing for all of us is, it's very easy to underestimate the importance of a doctor at any given moment in our lives. But I myself – I'm a very healthy person, but I had a couple of medical crises in the past, and I've never forgotten the tone of voice doctors used to me. Never forgotten the way nurses touched me or reassured me. So often a doctor's manner is the thing that you will never forget. It's not just what he's saying, it's how he's saying it. I think I'd like to build something of that into a scene with Dr Turner and Timothy going forward.

Stephen
I think it's, very simply, don't be scared not to know the answer. Don't be scared about the idea that something might stump you. A vulnerability in a medic is actually a deep human quality. Vulnerability, shared discovery, trying to find out from a basis of humility. Never, ever be scared of not knowing. Turner's been in a situation a few times where some of the best things he's ultimately achieved have been based on something which has stumped him, something which has challenged him personally.

To a young medic coming now – don't be scared to be human. Don't be scared to be human. Putting on a white coat, it's not a zero-sum game. It doesn't negate you. Don't flush away all those immense parts of your humanity that you have, the minute before you put that coat on.

I am very privileged to, every year or so, give a workshop for medical humanities students at Imperial College London. These people are brilliant students, and obviously being med students, they're pretty bright at a lot of things. They've called me in because they would like, as an actor, they would like me to give them the ability to talk easily or communicate easily.

What I end up saying to them more often than not is, ‘How many of you were at the top of your class in drama?’ and a few hands will go up at the back, and I'll say, ‘How many of you were top English literature students?’ and even more hands will go up.

And I say, ‘Do you know what? What I’m asking you to do is remember those parts of you. They never went away. The parts that studied great books, the parts that looked into the morality of religion, or human personality within the context of drama. You were good at all those things at school. You are great people. Harness those other sides. Don't forget them when you become your chief thing, a physician, which is all of those things.’

And I'm always very pleased and a bit jealous when they then get up and are absolutely 10 times better than me at performing, because usually they are.

Martin
A very final question, looking at real doctors, but I think in this case we can extend it to nurses and midwives, who has inspired you?

Heidi
I'm a huge admirer of Professor Iain Hutchison, the maxillofacial surgeon. I have seen documentaries about his work and read about some of his developments and the things he's instigated. I really admire him because in operating on the face, he fully acknowledges that you're operating on the person, at the deepest level; you really are manipulating some aspects of their soul.

But the work he's done through his Saving Faces foundation – not just in terms of promoting, facilitating, even funding research into cancers and how that can affect the face – he commissioned an extraordinary series of paintings of cancer patients, both before, during and after extensive maxillofacial surgeries. Very, very strong, fantastic oil paintings, quite large in scale, and these toured in an exhibition and continue to tour and have now been seen by two million people worldwide.

I think it's absolutely wonderful to see that conjunction of science, medicine and art. And I think something that's cropped up throughout this discussion has been the power of the elision of medicine and the humanities. So, Professor Iain Hutchison really gets my wholehearted admiration and applause.

Martin
And Steve, who gets your support? Who do you admire?

Stephen
Oh, I'm going to be so cringe now and embarrassing – I'm going to praise you. I've already praised Professor Gilbert for her ground-breaking work on the vaccine. But as we're here, you know what I really love about you, Martin, on a personal level, you came from a background probably not wildly dissimilar from me, and your social contexts are interesting and unique to you.

And for you to sit at the top of such an important and influential role in medicine – from somebody sitting on the outside – makes me feel very secure in the future for wider medicine, and in the fact that people can bring so much of their life's experience right to the top of the discussion of medicine in our daily life.

It's what, in the tiniest way, I've tried to do in my life. But you've achieved it so well. We need people like you, Martin. We need everybody, to the exclusion of no one. We need our society to be reflected in the medicine we discuss and the policies we write, and you do that very well.

Martin
Well, thank you very much. What can I possibly add?

Stephen
I will accept money.

Martin
Steve McGann, Heidi Thomas – thank you so much indeed for sharing your experiences and your ideas with us on this podcast. Thank you very much.

Heidi
Thank you.

Stephen
It's a pleasure.

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