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The delivery of health services as resistance

Ryan Essex

Institute for Lifecourse Development, University of Greenwich, London, UK

Correspondence
Ryan Essex, Institute for Lifecourse Development, University of Greenwich, Old Royal Naval College, Park Row, Greenwich, London SE10 9LS, UK.
Email: r.w.essex@gre.ac.uk

Abstract

In this article, I will argue that the delivery of healthcare could be an act of resistance, that is, day-to-day, routine and perhaps mundane acts, undertaken in the course of the delivery of health services, which for many could also be considered otherwise routine care. I first consider how resistance has been conceptualised. How we understand resistance will determine if we believe healthcare could be conceptualised this way. I will show how resistance has been applied to day-to-day struggles elsewhere and argue that it can clearly encompass open, collective dissent and more subtle, day-to-day action that does not necessarily make clear political demands. I go on to introduce some examples, where the delivery of health services could be conceptualised as resistance. While I advocate for a broad understanding of resistance, clearly not every act could be considered resistance; I will consider some points of tension and contention in utilising resistance to describe the delivery of health services, in particular discussing the issue of intent and opposition as they relate to resistance. Finally, while I hope that I make a convincing case, one final issue remains, namely, why turn to resistance at all, when many of the examples that I provide could be labelled using concepts that are more widely utilised. I will offer some general reflections on this point, speaking to the benefits and potential of resistance.

KEYWORDS

activism, healthcare, health workers, protest, resistance

1 | HEALTHCARE, RESISTANCE AND OTHER ADJECTIVES

In late 2021, I asked National Health Service (NHS) staff in the United Kingdom about the types of protests that they engaged in.[1] All were politically active outside the workplace and had engaged in various forms of protest, from civil disobedience, sit-ins and marches to more conventional engagement with electoral politics. I also asked about their acts within the workplace. They again disclosed a range of actions, including protests against the privatisation of services within the NHS and a number of other confrontational and disruptive acts. I heard stories about people forming alliances and establishing networks, working together to undermine punitive and hostile policies that charge migrants for the services that they received. There were even actions, that, at first glance, may not fit as easily with traditional conceptualisations of resistance. For example, one participant who was concerned about climate change made it a habit to switch everybody's computer off at the end of the day. When

[1]Ethical approval for this study was granted by the University of Greenwich Research Ethics Committee (UREC/21.1.6.10).

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confronted about this, they persisted despite being warned about this behaviour. While these acts raise a range of questions in themselves, several other acts were disclosed that will be the focus of this paper, that is, acts of resistance in the course of delivering health services. These actions otherwise resembled unremarkable acts that were the result of subtle decisions made in delivering these services; spending extended periods of time with patients who had greater needs and demedicalising language are just two examples. Could these otherwise routine and unexceptional acts of care be acts of resistance?

When we look elsewhere, we find that healthcare systems have been labelled a range of things: hierarchical,[2] oppressive,[3] patriarchal,[4] violent and coercive[5] and even 'systemically and institutionally deaf, bullying, defensive and dishonest.'[6] To contrast this, we can also see healthcare systems labelled as empowering and patient-centred.[7] It is, of course, completely possible that any one healthcare system could be any, none or all of these things. Looking to the individual acts that comprise healthcare systems, we find a range of similar labels applied. Historically, we find healthcare workers engaging in racism and other discriminatory practices.[8] This itself could be resisted; much has been written about 'noncompliant' patients.[9] We also find the day-to-day actions of health workers labelled a range of things, dilemmas, dual loyalty conflicts[10] or workarounds[11], all terms used to describe the conflicts that healthcare workers face on a day-to-day basis and the action that could be taken to mediate these. While I will also discuss examples of healthcare systems below, this paper will primarily focus on the day-to-day actions carried out by healthcare workers, acts that might otherwise seem routine and unremarkable. For simplicity, I will term these acts (as I have done above) the delivery of health services. This paper will also use the term healthcare workers to refer to those who are professionally regulated: doctors, nurses and the broader allied health workforce. While much of what I say could be applied to others who work in healthcare settings, the vast majority of the research carried out in this space has been carried out with these professions in mind.

It seems possible that under the right set of circumstances, the delivery of health services could also be labelled resistance, in addition to any other labels that we might apply. As I will show below, it is perhaps not this assertion that will be most contested; throughout the literature we can find examples that are quite clear-cut: healthcare that has resisted the status quo or undermined oppression. Perhaps the more contentious question relates to when it is appropriate to label the delivery of health services as resistance and, not only this, what we gain in doing so. Before getting to these questions, however, whether we understand the delivery of health services to be resistance will depend most fundamentally on our understanding of resistance. Below, I will first introduce the concept of resistance and discuss some of its conceptual controversies. Importantly, I will argue that it is a concept that can readily accommodate acts that are often unremarkable and even mundane without specific political demands, acts that may not traditionally be considered as resistance. To illustrate my point, I will introduce a number of examples, from my own research and a number of recent studies. I will then go on to consider some points of tension and contention in turning to resistance. While I advocate a broad conceptualisation, clearly, not every act carried out by health workers could be considered resistance. I argue that it is necessary to look at the extent to which broader systems and structures allow or constrain health or the delivery of healthcare. Finally, I will also discuss what the possible benefits may be in turning to resistance over other related concepts to describe the delivery of health services.

2 | WHAT IS RESISTANCE?

In understanding how the delivery of health services could be resistance, it is first important to outline what is meant by resistance. Resistance is an umbrella term assigned to a range of actions, including more public, confrontational and disruptive actions, such as civil disobedience, marches and sit-ins, acts that often make clear demands or have some type of opposition in mind. Resistance also encompasses more subtle, everyday actions. These actions are not necessarily public, are often carried out by individuals and are not necessarily confrontational or disruptive and may, in many cases, lack the hallmarks of more traditional acts of resistance. It is this type of resistance that I am primarily interested in here. In exploring the concept of everyday resistance, we cannot go past the work of Scott,[12] whose work was influential in defining what was at the time an emerging field of study. Everyday resistance is one of the more popular terms for such action. For Vinthagen and Johansson,[13] everyday resistance refers to action that is 'quiet, dispersed, disguised or otherwise seemingly invisible.' More practically, acts such as feigned ignorance, sarcasm, passivity, humour and desertion are some

[2]Ferguson, H., & Anderson, J. (2021). Professional dominance and the oppression of the nurse: The health system hierarchy. *Australian Nursing and Midwifery Journal*, *27*(4), 30–31.
[3]McConnell, D., & Phelan, S. (2022). The devolution of eugenic practices: Sexual and reproductive health and oppression of people with intellectual disability. *Social Science & Medicine*, *298*, 114877.
[4]Cowan, H. (2021). Taking the national (ism) out of the National Health Service: Re-locating agency to amongst ourselves. *Critical Public Health*, *31*(2), 134–143.
[5]Rudge, T. (2011). The 'well-run' system and its antimonies. *Nursing Philosophy*, *12*(3), 167–176.
[6]Pope, R. (2019). Organizational silence in the NHS: 'Hear no, see no, speak no'. *Journal of Change Management*, *19*(1), 45–66.
[7]Thesen, J. (2005). From oppression towards empowerment in clinical practice—Offering doctors a model for reflection. *Scandinavian Journal of Public Health*, *33*(66_suppl), 47–52.
[8]Antonovich, J. (2021). White coats, white hoods: The medical politics of the Ku Klux Klan in 1920s America. *Bulletin of the History of Medicine*, *95*(4), 437–463.
[9]Conrad, P. (1987). The noncompliant patient in search of autonomy. *Hastings Center Report*, *17*(4), 15–17.
[10]Pont, J., Stöver, H., & Wolff, H. (2012). Dual loyalty in prison health care. *American Journal of Public Health*, *102*(3), 475–480. https://doi.org/10.2105/AJPH.2011.300374
[11]Debono, D. S., Greenfield, D., Travaglia, J. F., Long, J. C., Black, D., Johnson, J., & Braithwaite, J. (2013). Nurses' workarounds in acute healthcare settings: A scoping review. *BMC Health Services Research*, *13*(1), 1–16.
[12]Scott, J. C. (1989). Everyday forms of resistance. *The Copenhagen Journal of Asian Studies*, *4*, 33.
[13]Vinthagen, S., & Johansson, A. (2013). Everyday resistance: Exploration of a concept and its theories. *Resistance Studies Magazine*, *1*(1), 1–46.

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examples that fit comfortably with this definition of resistance. Such resistance has traditionally been conceptualised as being used by those where more open or oppositional acts may be too risky, and while such acts require little coordination, Scott[14] argues that such acts can evolve into a larger pattern or culture of resistance.

In attempting to identify the more specific elements in conceptualising resistance, along with its controversies, it is instructive to turn to Hollander and Einwohner,[15] who developed a framework to describe the common and contested features present in conceptualisations of resistance. The first two features, action and opposition, are generally accepted features of resistance. That is, resistance generally opposes something and involves some type of action. The next two elements, visibility and intent, are more controversial. While most agree that an act need not be visible (to the authorities, for example) to count as resistance, intent poses more of a problem, namely, if an actor needs to recognise their actions as resistance. A clear problem when it comes to intent is that if we exclude it completely, almost any action could be labelled resistance; we run the risk of losing all conceptual purchase. On the other hand, however, requiring that actors have clear intent in relation to their actions risks missing important acts of resistance. Some have argued that while people may perform acts that resemble everyday resistance, like showing indifference, using humour or 'cutting corners', without intent, these acts are not best described as resistance.[16] This position, however, has been challenged by a number of authors. That is, while some have maintained that it is still important to probe intent; others have called for greater focus on the impact or outcomes of the action in question.[17] Taking a similar position, Vinthagen and Johansson[18] argue that while every action is carried out with intent, it is never 'with one type of intent: neither necessarily a political-ideological one, nor antagonistic class interest'. They go on to argue that intentions could be multiple and that requiring resistance to have some type of political awareness risks excluding 'not-yet political awareness, or differently motivated resistance'.[19] In then assessing whether an act qualifies as resistance, they argue that context matters and that to assess this, we need to consider 'contextual tactics, opportunities, individual choices…' among other factors. Alongside discussions about intent, several other concepts have emerged that build upon and challenge the traditional conceptualisation of everyday resistance; for example, 'quiet encroachment' has been described as the 'the silent, protracted but pervasive advancement of the ordinary people on the propertied and powerful in order to survive and improve their lives… marked by quiet, largely atomized and prolonged mobilization with episodic collective action'.[20] Other conceptualisations have challenged the often dichotomous way in which individual or everyday acts are divided from more traditional, public and collective acts of resistance.[21]

Despite these tensions and ongoing discussion in relation to the nature of resistance, it is a concept that has been applied to a range of struggles and can clearly encompass a range of actions, including that which may otherwise appear routine or unremarkable. Importantly for these purposes, how we understand resistance will dictate whether we believe that the delivery of health services fits this label. On one of the most contentious aspects of resistance, intent, I take a position similar to those described above, namely, that while intent is important, so are the consequences of the action in question and the context in which it occurs.

3 | HEALTHCARE AS RESISTANCE, SOME EXAMPLES

While resistance has been applied to a range of struggles, explorations into the relationship between resistance and health are in their infancy.[22] Looking closely at this relationship, however, we can find health-motivating protest actions and we can also see movements and actions framed in terms of health.[23] Looking to recent history, we can also see numerous examples of how activism has challenged and changed health-related knowledge and practice.[24] In many cases, these actions have clear goals, many are public and for most, we can see clear links between the action itself and health. We also do not have to look very far to find examples where the delivery of care fits comfortably alongside these definitions of resistance. We can see how the Black Panther health clinics and sickle cell screening programme delivered a critical health service, while challenging racism and the neglect of mainstream of healthcare services.[25] We can see multiple examples of how orthodox psychiatric treatment has been resisted by rethinking and challenging existing approaches to treatment and intervention.[26] We can also see examples throughout particularly dark times of human history: the healthcare provided throughout the Jewish ghettos during World War II that

[14]Scott, op cit. note 12.
[15]Hollander, J. A., & Einwohner, R. L. (2004). *Conceptualising resistance* (Vol. 19, pp. 533–554). Springer.
[16]Kerkvliet, B. (2009). Everyday politics in peasant societies (and ours). *Journal of Peasant Studies*, *33*(1), 227–243.
[17]Bayat, A. (2000). From Dangerous Classes' to Quiet Rebels' Politics of the Urban Subaltern in the Global South. *International sociology*, 15(3), 533–557.
[18]Vinthagen & Johansson, op cit. note 12.
[19]Ibid.
[20]Bayat, op cit. note 17.
[21]Lilja, M. (2022). The definition of resistance. Journal of Political Power, 15, 1–19; Lilja, M., & Vinthagen, S. (2018). Dispersed resistance: Unpacking the spectrum and properties of glaring and everyday resistance. *Journal of Political Power*, 11(2), 211–229.
[22]Essex, R. (2023). The intersections of health and resistance. In *Oxford research encyclopedia of global public health*. https://doi.org/10.1093/acrefore/9780190632366.013.494
[23]Liu, A. K., Ophir, Y., Tsai, S.-A., Walter, D., & Himelboim, I. (2022). Hashtag activism in a politicized pandemic: Framing the campaign to include Taiwan in the World Health Organization's efforts to combat COVID-19. *New Media & Society*.
[24]Roth, B. (2017). *The life and death of ACT UP/LA: Anti-AIDS activism in Los Angeles from the 1980s to the 2000s*. Cambridge University Press.
[25]Bassett, M. T. (2016). *Beyond berets: The Black Panthers as health activists* (Vol. 106, pp. 1741–1743). American Public Health Association.
[26]Robcis, C. (2021). *Disalienation: Politics, philosophy, and radical psychiatry in postwar France*: University of Chicago Press.

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undermined the goal of the Nazis to 'eliminate the inhabitants by starvation, epidemic, and exposure'.[27] More recently, throughout the 2011 civil war in Syria, in what quickly became a war of attrition, many health staff stayed behind, providing care in underground hospitals. In addition to these examples, we can find a small empirical literature that provides insight not only into how the delivery of health services that could be considered resistance but also how this manifests in the day-to-day actions of healthcare workers. Mainey, O'Mullan and Reid-Searl[28] explored how nurses met the needs of their patients seeking abortions in Australia. In one vignette, Mainey et al. describe how employees working for a Catholic hospital (where abortions were banned) communicated in code, disguising abortions as routine care, including admitting patients for abortions under fabricated diagnoses, while prochoice health staff worked together to keep antiabortion staff rostered away from the procedure. A range of other acts is also reported, from subversion, to examples of nurses impersonating doctors to make referrals for abortions. Far removed from rural Australia, a body of work by Shutzberg[29] details how Swedish GPs manipulated medical certification for the Swedish Social Insurance Agency. At least eight techniques were identified, including exaggeration, quasi-quantification, omission, depersonalisation of the patient voice, adjustment of disease progression, buzzwords, communication off the record and production of redundant somatic data. These were most often employed when GPs felt that a certificate was at high risk of being rejected.[30] My point in drawing attention to these examples is to show that the delivery of health services, in many respects, sits comfortably with the above conceptualisation of resistance. I hope that for many, this will not be controversial and that, under the right circumstances, the delivery of health services can act in opposition to oppression, racism and violence. It can even challenge us to imagine new and better approaches to care. But as I said above, where does resistance start and end? The examples that I have provided above have often occurred in exceptional circumstances, war and social upheaval. Below, I want to introduce some examples of resistance that were reported in the normal, day-to-day operation of the UK's National Health Service (NHS), in what would otherwise be unexceptional circumstances. The first comes from a health worker who would see patients for an extended period of time, if they felt it was warranted[31]:

> I was working in [specialty] for about eight months at one point and a lot of vulnerable people come through the door and it's a walk in clinic so you're meant to take 20 minutes, half an hour, with each patient at most, but I would take two hours if the patient needed two hours, and I would take the time to find the interpreter if it took time… I think that's just prioritising patient care over the rules in place (P9)

Another participant spoke about their efforts to challenge norms in mental healthcare. This involved speaking to families about the 'different ways of thinking about mental health and mental distress' and that supporting people with a mental illness can be approached in different ways than 'just nagging them to take the medication' (P25). At times, they also sought to challenge the medication that patients were prescribed, and while rarely successful, at times, they found themselves working with others who shared their view and 'made real headway in terms of reducing people's prescriptions' (P25). This approach extended into how this participant delivered therapy, treating patients with dignity:

> So we were doing our own thing that… wasn't a revolutionary thing… talking therapies with nice, comfortable furniture, and people came off the wards. It was like a day hospital within the hospital. But it was recognised as a place of… and I don't want to over exaggerate, but there was a little bit of a sanctuary within the hospital, and people were treated right. And it made some contribution to positive outcomes. (P25)

In a somewhat similar fashion, another participant spoke about attempting to demedicalise the language that they used, particularly when speaking with patients; they elaborated: 'when you're writing to patients that can often seem quite pathologizing. I've tried to just write, most of my letters to the patient, so I'm speaking to them directly, and not about them… I see that as a way of humanising that that process for people' (P37). This participant went on to speak more broadly about how the act of providing patien-centred care in itself could be an act of resistance: 'you do hold a lot of power and I think those interactions are really important and can be transformational. I've become a lot more hopeful about that. I know that individual acts and actions by themselves aren't necessarily going to change the system, but I do feel like those one to one interactions that you have with people can be really powerful and can kind of break down barriers and provide kind of, radical care…' (P37).

In addition to the above examples and as I noted in the introduction, participants spoke about a range of other actions that may be considered resistance; this included more overt protest within the workplace, challenging more senior staff or even undermining processes that sought to charge those without identification for the services that they received. I have deliberately highlighted the above examples because they best illustrate my point; they are unremarkable acts that could be seen as routine. But do these actions

[27]Longacre, M., Beinfeld, S., Hildebrandt, S., Glantz, L., & Grodin, M. A. (2015). Public health in the Vilna Ghetto as a form of Jewish resistance. *American Journal of Public Health*, *105*(2), 293–301.

[28]Mainey, L., O'Mullan, C., & Reid-Searl, K. (2022). Resistance in health and healthcare: Applying Essex conceptualisation to a multiphased study on the experiences of Australian nurses and midwives who provide abortion care to people victimised by gender-based violence. *Bioethics*, *37*(2), 199–207.

[29]Shutzberg, M. (2019). Unsanctioned techniques for having sickness certificates accepted: A qualitative exploration and description of the strategies used by Swedish general practitioners. *Scandinavian Journal of Primary Health Care*, *37*(1), 10–17.

[30]Ibid.

[31]These interviews were carried out in late 2021 with NHS workers in the UK. Ethical approval for this study was granted by the University of Greenwich's University Research Ethics Committee (UREC/21.1.6.10).

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fit the above conceptualisation and where might particular tensions lie in applying the label resistance?

4 | TENSION AND CONTENTION IN CONCEPTUALISING HEALTHCARE AS RESISTANCE

Above, I have provided several examples of day-to-day care that would under most circumstances be considered common and unremarkable, but could we label these everyday and routine acts resistance? Below, I want to reflect on some of the potential points of tension and contention in labelling the delivery of health services resistance. While I will focus on the acts that I have introduced above, I hope that this discussion has broader relevance to the existing research in this area and how we think about the delivery of healthcare more generally. To begin this discussion, I will return to the framework that I introduced above of Hollander and Einwohner[32] and their approach detailing the elements of resistance: action, opposition, visibility and intent. In particular, I want to focus on two issues that I believe may raise the most contention: intent and opposition.

As I have mentioned above, one of the most contested elements of resistance relates to intent (and motivation).[33] Is the doctor providing care to undocumented migrants engaging in an act of resistance? On the one hand, they could be simply be seen as fulfilling their professional obligations, providing care to vulnerable people; on the other hand, however, these actions could also serve to undermine oppressive government policies that demonise migrants. Intent is notoriously difficult (or impossible) to assess and as can be seen from the above example, it is something that can get away from us fairly quickly when we begin to think about the multiple motives that lead to any given action. In saying this, it is worth briefly reflecting on this point, in light of the above interviews. While many of the participants identified the above acts as resistance (at least in retrospect), some were more sceptical, maintaining that such actions were 'not major act[s] of resistance' and that these were better explained as 'people working within the system to try and get him what he needed' (P16). Considering others' intent and motivation adds further complexity to this picture. Several participants spoke about such action being motivated because of the nature of their roles as health workers. One participant spoke about the pride that they felt in the NHS but felt, as a health worker, that its neglect and underfunding should be opposed. Perhaps more to the point, one participant spoke about resistance as central to being a 'good' nurse, arguing that health workers should not ignore problems when they arise and that this 'could extend to wider systemic problems with the NHS… and trying to do something about it and not just accepting that what the managers or the government says is right' (P16). Others expressed similar sentiments; however, for many, this also came from a position of being uncomfortable with the status quo, with the healthcare system and other health workers around them. Despite having good intentions in starting out in their role, one participant spoke about the dissonance that they faced after finding themselves in a 'system that's oppressive, coercive, its poorly resourced' (P25). Similarly, others noted that the systems in which they worked did not allow them to deliver the services that they were trained to deliver. In considering intent in this instance, the most contentious issue should not be whether intent was present or absent, but whether the intention of the action was to resist or was to simply provide the best care for patients under a range of constraints (or aimed at achieving any other number of outcomes for that matter). At least one participant identified that they were opposing the government or management. But for others, is this resistance or simply being a good clinician, given the circumstances? On this point, Vinthagen and Johansson[34] argue that resistance can entail 'the silent, mundane and ordinary acts that are normalized' with actors themselves, seeing such acts not as resistance, but as 'a normal part and way of their life, personality, culture and tradition'. Even without intent, these otherwise routine acts could be labelled resistance. In saying this, clearly, not every instance where a health worker attempts to do their best by a patient fits this label. In exploring the above examples, more context in needed, particularly in relation to what is being opposed; this is something I will discuss below.

One thing that is not readily apparent in the examples that I have provided above relates to what is being opposed. In speaking with health workers, I did not have a specific opposition in mind like other studies that were carried out in light of relatively specific policy or law that imapcted the delivery of health services, whether this be restrictions placed on access to abortion or government encroachment into clinical decision-making, for example. This leaves open the question of opposition. What precisely was being opposed by seeing a patient for an extended period of time or in demedicalising language in patient notes or simply treating patients with dignity?

The first point worth considering here is that many of the above actions were simply not opposing anything. Namely, many of the above actions resemble compliance with what might be expected. That is, demedicalising language for patients should be the norm, as should extended appointments for patients who need the extra time. Discussions about the relationship between power and resistance are instructive here. While the precise relationship between power and resistance is contested, resistance 'not only challenges or provokes power but sometimes ends up supporting power'.[35] That is, we find examples where resistance may simultaneously involve compliance or even support or re-enforce power. Some have described this relationship as cyclical: 'domination leads to resistance, which leads

[32]Hollander & Einwohner, op. cit. note 15.

[33]Shutzberg (2020) argues that while intent and motivation are closely related, a distinction can be drawn between the two, namely, that intent generally refers to the aim of the action in question, while motivation explains *why* this action is carried out. Above, I take this distinction for granted as I discuss a range of actions, with different intentions; this distinction, however, is an important consideration in attempting to disentangle discussions about resistance.

[34]Vinthagen & Johansson, op cit. note 12.

[35]Lilja, op. cit. note 21.

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to the further exercise of power, provoking further resistance, and so on',[36] while others suggest that this overlooks how the production of resistance 'is an open-ended and historically emerging process', but also because resistance is 'embedded in simultaneous combinations of several powers', that is, we may resist one power while embracing others.[37] We can see examples of this in Shutzberg's[38] work, where resistance took the form of compliance, namely, that in issuing medical certificates, '[t]o evade the regulatory conditions set by the insurance agency, GPs go to great lengths to appear as if they are closely adhering to these regulatory conditions'. The same could be said about the actions discussed above, namely, that they were adhering to the rules by one standard, namely, the service that health workers should ideally aim to provide, while at the same time resisting. We can see how spending two hours with a patient could resemble a work to rule strike; if every patient in the NHS was given the time that they needed, the system would likely buckle. This is what Shutzberg[39] labels 'resistance through compliance'. We can also see examples of what could be labelled resistance underneath compliance, where resistance depends on a veneer of compliance being maintained, such as the participant who delivered mental healthcare, at the same time challenging the status quo by treating patients with dignity and pushing for prescriptions to be reviewed.

Regardless of whether the above acts were compliance, the question remains: if the above acts were resistance, what was being opposed? While each of the above acts was likely carried out with slightly different opposition in mind, they have one uniting feature, namely, their opposition to the systems or norms that restricted the ability to delivery these services. That is, key in assessing whether such acts are resistance first requires us to look at the context in which these services are delivered and the extent to which they enable or constrain the delivery of health services, or how these acts were 'intertwined with power, affects, agency, temporalities, spaces and other forms of resistance'.[40] This is illuminated by one participant, who reflected on their role in a previous position, where actions that may have otherwise been contentious in a hospital environment were encouraged and facilitated by management:

> I worked in a GP practice that specialised in care for asylum seekers and homeless people and I think that people there had a much more clued up… they were actively doing things around the immigration system and stuff like that, but it didn't feel as much like resistance because the whole organisation was doing it. It came from the top, the managers were saying, 'yeah, that's great'. But I suppose that was resistance in a way, against government. When I was working there and it was very clear you didn't ask about someone's immigration status. When you registered them you just did it. They had a policy of not asking for ID and not asking for proof of address and things like that. Then when people moved on sometimes the practice manager would ring other practices and say you shouldn't be asking for ID. Maybe that would have been classed as resistance in the hospital. A hospital wouldn't have done any of that. (P16)

Returning to and applying this to some of the other examples above, it may be that spending an extended period of time with a patient is not an act of resistance, where systems are well staffed and where this is actively encouraged, nor would treating a patient with dignity, where this is enabled. If the norm or expectation is that everyone is seen within a 10 min window, regardless of their needs, then extending appointment times may be an act of resistance, against what is expected or against what might otherwise be accepted by colleagues. It could be an act against a system that is one size fits all or the expectations of others within this system. Attempting to uphold the dignity of psychiatric patients would not be an act of resistance if this was done as the norm. As I noted above, while all of the acts above are drawn together around their opposition to systems or norms that restricted the ability to delivery these services, this is still quite general and beyond the discussion offered here; it is likely that the picture here, as it relates to opposition, is far more complex.

Above, I have discussed how the delivery of health services could be conceptualised as resistance, some of the potential limits of the concept and tensions in applying this label. I have argued that such routine actions should be assessed in the context in which they occur, notably the extent to which systems and structures enable the delivery of healthcare. For clarity, there may be good reason to constrain the ability to deliver certain forms of care or restrict certain acts. This may involve limiting the types of procedures carried out by trainees, for example. With the conceptualisation that I have provided above, it is also completely plausible that such acts could be labelled resistance: the trainee doctor who defies their superiors to carry out a procedure for which they may not yet be competent. While this is resistance, its justification is far more questionable. Below, while I will not deal with the many normative elements that resistance raises, I will deal with one further point, namely, that labelling such acts as resistance is unnecessary; we already have labels that adequately describe the actions above, namely, work-arounds or working within the constraints of the system, as suggested by at least one participant above.

5 | WHAT WE GAIN FROM UNDERSTANDING HEALTHCARE AS RESISTANCE

What do we gain and what are the trade-offs in labelling an act resistance? And why might it be better than other labels that we could apply? For example, the participant who spent an extended

[36]Hollander & Einwohner, op. cit. note 15.
[37]Vinthagen & Johansson, op cit. note 12.
[38]Shutzberg, M. (2020). Literal tricks of the trade: The possibilities and contradictions of Swedish physicians' everyday resistance in the sickness certification process. *Journal of Resistance Studies*, *6*(1), 8–39.
[39]Ibid.
[40]Lilja & Vinthagen, op. cit. note 21.

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period of time with a patient could also be seen as having a dual loyalty conflict between their patients' best interests and what may otherwise be expected from their manager or by other norms in that particular context. While I acknowledge that it has commonalities with other concepts and while further work should be done to distinguish between resistance and concepts such as work-arounds and dual loyalty conflicts, below, I will argue that resistance has a number of benefits when used to describe the delivery of health services, namely, in how it helps to politicise the everyday, what it says about power and healthcare systems, how it helps (re)frame several normative problems and finally, in understanding how health is impacted, protected and contested.

Resistance helps us see how otherwise unremarkable, mundane, routine acts are political. This speaks to several points, but provides insight into how power shapes resistance and how systems, structures and norms, among other things, restrict or enable health workers to speak up or raise concerns. It also shows us that resistance happens everywhere, everyday, not only as it relates to major injustices or discrimination or unfairness. Resistance also exists in undermining rules or policy, in maintaining the dignity of those who would otherwise be unheard. It also shows how each of these things is interconnected. While the focus of this paper has been individual actions, such actions, while disparate and uncoordinated, can have 'aggregate consequences all out of proportion to their banality'.[41] In connecting these acts, we see not only how these acts may be labelled an isolated work-around or dual loyalty conflict, but how we might begin to think of this response to such action as a failure of systems or structures around the individual.

On this point, importantly, resistance speaks to more than individual acts, but failures in structures and systems that should support and enable the delivery of healthcare. It shows how systems, policy or procedure may be deeply flawed or inadequate, where there otherwise may seem to be little dissent. It shows that measuring satisfaction and the quality of care is far more difficult than looking to metrics and surveys. In many ways, it says more about power and the systems in which people work than the individual acts themselves. It helps us identify points of conflict and even provides insight into how inadequate systems are sustained despite their shortcomings. Importantly, in framing acts as resistance, we are no longer working around inadequate systems, we are opposing them, we are no longer coping with broken systems, we are creating something better. Understanding the delivery of health services as resistance also sheds light on and helps us understand how health systems could be oppressive or discriminatory.

Resistance also helps us (re)frame a range of normative problems that are raised in the delivery of health services. It raises distinct questions about the conduct of healthcare workers and when it may be justifiable to depart from policy or challenge norms. Beyond these questions, however, it also raises pressing questions as they relate to the broader forces that challenge health; it not only sheds light on conflicts and opposition but also its causes. One of the points that has already been widely discussed in the literature relates to the fact that such action often does not confront power and in many cases, it may re-enforce systems and allow them to continue to function. That is, while more open protest often has clear demands and can be confrontational, everyday acts, 'by not openly contesting norms of law, custom, politeness, deference, loyalty and so on leaves the dominant in command of the public stage'.[42] This raises further questions about in what circumstance such action may be most appropriate, as opposed to more openly oppositional action. It also raises questions about how quiet discontent promotes or restrains more open action, such as strikes and protest.

Finally, bringing resistance into the discussion sheds light on an important force that has shaped health and well-being. We can find subtle day-to-day actions, supporting broader protest and contributing to important gains in areas such as disability rights[43] and the fight for sanitation and clean water.[44] Day to day, we can see how such action shapes healthcare encounters, providing safety and upholding the dignity of those who might be neglected or oppressed by broader healthcare systems. We can also see how such action, beyond simply being oppositional, can help us imagine new and better futures by 'embrac[ing] reverse discourses, meaning-making and the negotiating of 'truths', as well as the creation of other ways of life through counter-conduct and techniques of self'.[45] This leads to my final point, that resistance is fundamentally hopeful, that we are not resigned to the status quo and that we can always imagine and do better.

CONFLICT OF INTEREST STATEMENT

The author declares no conflict of interest

ORCID

Ryan Essex http://orcid.org/0000-0003-3497-3137

AUTHOR BIOGRAPHY

Ryan Essex is a research fellow at the University of Greenwich. His research focuses on the intersections of resistance and health.

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[41]Scott, op cit. note 12.

[42]Scott, op cit. note 12.

[43]Stramondo, J. A. (2022). How disability activism advances disability bioethics. *Ethical Theory and Moral Practice*, *25*(2), 335–349.

[44]Hamlin, C. (2008). *Health of towns association* (act. 1844–1849).

[45]Lilja & Vinthagen, op. cit. note 21.

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