



Exploring non-violent resistance amongst healthcare workers

Survey briefing



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Acknowledgements

Thank you to all those who took part in this survey. If you have any questions about the survey, would like any further information, or would be interested in receiving a copy of publications arising from this research and/or participating in any future research, please email r.w.essex@gre.ac.uk, hilaked@medact.org, rebeccadaniels@medact.org.

Summary

While remarkably common, there has been little serious study focused on the relationship between health and non-violent resistance and the actors involved in this space. This remains the case for actions and movements where healthcare workers are involved. To address this gap in our understanding, we sought to ask Medact members about their understanding of non-violent resistance, the barriers they faced in engaging in such action and their thoughts on the justification of such action.

The results speak to the complex and contingent nature of non-violent resistance, with a range of actions and issues identified, from public and disruptive action, to more individual and hidden acts. In terms of the justification of such action, many raised concerns about how closely the issue being protested was related to health or healthcare, while many also raised concerns about the nature of the action, whether it would impact patient safety and whether it was non-violent.

While a range of barriers were identified in relation to engaging in non-violent resistance, concerns about career, registration and arrest dominated, we also found that a general apathetic or unsupportive culture throughout healthcare made a number of participants think twice about engaging in such action.

We hope to use these results as a foundation for future research but also for advocacy in relation to engaging healthcare workers in effective campaigns and activism.

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1. Background

This briefing summarises the key results of academic research into healthcare workers' attitudes towards, and engagement in, non-violent resistance. It was conducted by [Dr Ryan Essex](#), a Research Fellow at the University of Greenwich's Institute of Lifecourse Development via a survey sent to Medact members in July 2021.

2. Who took part?

In total, 148 people took part. Age was relatively spread, however the majority of participants were over the age of 65 (n = 45, 30.4%). Seventy eight (52.7%) participants identified as women, 46 (31.1%) as men and 4 (2.7%) as non-binary.

Professionally, the majority of participants were doctors (n = 77, 52%), nurses (n = 13, 8.8%) and academics (n = 8, 5.4%). Most indicated they held a senior position (n = 63, 42.6%) either now or prior to retirement. Thirty-three (22.3%) and 28 (18.9%) participants indicated they held a mid-level or junior role respectively. Fifty-five (37.2%) respondents were retired. Of those who were retired, 19 (34.5%) had been retired for ten+ years, 12 (21.8%) for between five and ten years and 24 (43.3%) had been retired for less than five years.

The vast majority of participants indicated they were from a white background (n = 104, 83.9%), 12 (9.7%) participants indicated they were from Asian, African, Caribbean or mixed background, while eight (6.4%) participants indicated they were from other ethnic backgrounds.

3. Why explore non-violent resistance?

Non-violent resistance has received relatively little scholarly attention, despite the range of questions it raises: conceptual, normative, regulatory and more generally about the role of healthcare workers in society. This is surprising given its long history and the fact that it can take credit for many important health-related gains.

Over the last 12 months, a team at the University of Greenwich has been setting up an online platform to track non-violent actions carried out by healthcare workers across the globe and has also done substantial research into historical actions and movements.

This study sought to add an important element to these investigations by including the voices of healthcare workers, many of whom had been involved in non-violent resistance. Our survey sought to explore three main issues: 1) the concept of non-violent resistance itself; 2) the justification of non-violent resistance; and 3) the barriers faced by healthcare workers to engage in such action.

4. What is non-violent resistance?

The difficulties in conceptualising non-violent resistance and the broader term, “resistance” have been well documented in academic literature. The term has been described as having a “palpable lack of definitional consensus” (Hayward & Schuilenburg, 2014) and sits alongside a range of similar terms: “critical resistance”, “off-kilter resistance”, “civil resistance”, “non-violence resistance” (Baaz, Lilja, Schulz, & Vinthagen, 2016) and “dispersed resistance” (Lilja & Vinthagen, 2018). To further complicate this picture, non-violent resistance is often used interchangeably with a range of terms such as “activism”, “contentious politics” and “protest”.

When thinking about non-violent resistance, we may first think of more public, collective acts, such as marches and civil disobedience. This was how most survey participants understood non-violent resistance, as an umbrella term that incorporated public, often collective acts which may break the law. This understanding, of course, encapsulates the most visible and well known forms of non-violent resistance (e.g. civil disobedience).

However, our results also suggest that non-violent resistance was far more ubiquitous. Consistent with Scott’s (1986) concept of everyday resistance, a number of participants identified more subtle acts within the workplace. Feigned ignorance (for example of patients’ migration status) was one such strategy, and actively avoiding those who may charge or identify patients without documentation. Refusal was another, for example not doing certain elements of training (such as Prevent counter-extremism training). Leaving on time was also mentioned as a potential act of resistance, a form of action which has synergies with a work-to-rule strike or Scott’s identification of “foot dragging” (Scott, 1986). In follow-up, in-depth, semi-structured interviews conducted with 12 participants, health workers described acts as diverse as hiding immigration status forms and distributing anti-privatisation flyers as examples of resistance, as well as simply providing compassionate care within a system often not conducive to it.

In analysing the responses, we utilised a method called ‘content analysis’. This method counts the number of times a comment or theme is present in responses (White & Marsh, 2006). Below, figure 1 summarises these results. The diagram presents the major or overarching themes in the centre of the circle, moving outward to sub-themes. The number of responses is represented by the total area (how much or how little space) the theme occupies in the circle. We can see that when asked about what non-violent resistance was, most respondents spoke about the nature of non-violent resistance, that is, its function and the nature of violence/non-violence. Respondents also illustrated their response with examples, discussing the forms of action that fall under the umbrella of non-violent resistance. To a lesser extent, respondents spoke about the oppositional nature of non-violent resistance and their motivations for such action.

We were also interested in whether participants felt non-violent resistance was distinct when carried out by healthcare workers. While opinion was divided, many felt that healthcare workers could bolster the legitimacy or credibility of action and increase its publicity or reach. However, being a healthcare worker could sometimes constrain action, as well as conversely, on occasion, provide certain opportunities. That is, many participants commented on the relative authority and trust that healthcare workers had, which some felt meant they had more of an obligation to act, while others called for caution, noting that such action could also

damage public trust. Importantly on this point, a number of participants didn't see non-violent resistance carried out by healthcare workers as being distinct at all, or only saw it as significant in as far as the public perceived healthcare workers as being trusted or an authority on an issue. Figure 2 summarises the major themes that emerged in relation to this question.

Figure 1. What is non-violent resistance?¹



¹ **How to interpret a sunburst chart:** This chart represents all responses to the question about the nature of non-violent resistance. The overarching themes are in the centre of the circle, with sub-themes found further out. The space occupied by each theme represents the number of participants who mentioned it. For example, in this figure, a little more than half of the participants spoke about the nature of resistance itself, with most mentioning the role of violence or harm in such action and its functions, namely its oppositional, didactic and expressive/symbolic functions.

Figure 2. Is non-violent resistance distinct when undertaken by healthcare workers?



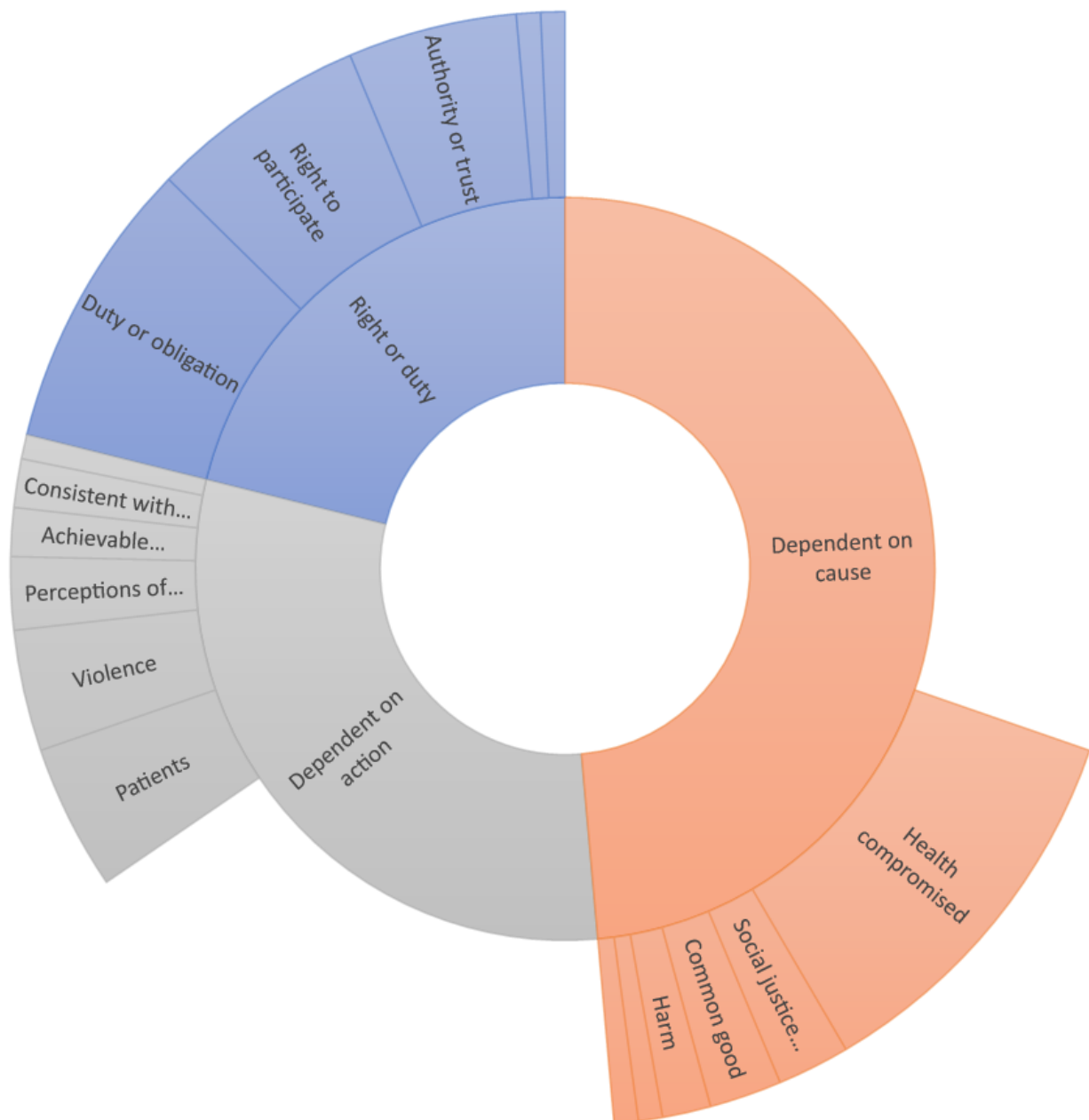
5. When is non-violent resistance justified?

Very little has been written about the justification of non-violent resistance as carried out by healthcare professionals. While there has been substantial work by political theorists as it pertains to healthcare workers, one of the most cited frameworks is from almost four decades ago (Childress, 1985). This framework asks a number of questions in relation to ‘illegal actions’ (i.e. civil disobedience) specifically pertaining to the aims of the action, whether it is a last resort, the possible consequences of the action (including its likelihood of success and the risks

in taking such action), and finally different types of 'disobedience', for example violent and non-violent acts and so on.

We saw a number of similar concerns in our results. Perhaps unsurprisingly, participants felt that non-violent resistance was justifiable under many circumstances with a number of people suggesting they felt that healthcare workers had a right or duty to engage in such action. In line with the above literature, a substantial number of people felt that it was first necessary to look at the aims of the action; some specified that these might be circumstances where health or healthcare is compromised, there is harm to people or the environment, or in addressing oppression or injustice. The action itself was also identified as being an important consideration, for example there may be a vast difference in justifying a march in comparison to civil disobedience. A number said that the action should not harm patients and not resort to violence. And like the above literature, a number of respondents also suggested such actions should be a last resort. Figure 3 summarises the major themes that emerged in relation to this question.

Figure 3. When is non-violent resistance justified?



6. What barriers are there to engaging in non-violent resistance?

On this question, we are unaware of any existing literature on this topic, so the results here are particularly novel. Broadly, participants identified personal, professional and other social concerns related to their involvement in non-violent resistance. Time was by far the greatest personal barrier, followed by concerns about the consequences of the action, health or caring limitations, as well as racism. On the latter, a number of participants raised concerns about the differential impact that protest policing may have on racially minoritised groups, as recent research on the policing of Black Lives Matter demonstrations shows (Elliott-Cooper, 2020),

with three respondents voicing that they were reluctant to engage in non-violent resistance because of their ethnicity.

Participants also had substantial concerns about the potential impact of such action in the workplace and on career progression. A number of people raised concerns about the fact that regulatory bodies in the UK (such as the General Medical Council and Royal College of Nursing) had not made their position clear on non-violent resistance. A substantial number also cite concerns about the potential legal consequences of such action, notably breaking the law or being arrested. Interestingly, a large number of participants also expressed fears about how such action may be perceived by colleagues or the public, suggesting that such action was not the norm and that there was a lack of awareness about such action in healthcare. It also seems that a number of people felt somewhat isolated in relation to this type of action, not having colleagues who would understand or support their actions. Figure 4 summarises the major themes that emerged in relation to this question.

Figure 4. What barriers are there to engaging in non-violent resistance?



7. Police, Crime, Sentencing and Courts legislation

In relation to barriers, we also specifically asked about the Police, Crime, Sentencing and Courts (PCSC) Act, at that time a bill in front of parliament and since passed into UK law. Participants were asked about how much they knew about the bill, with 49 (33.1%) participants indicating they knew a great deal, 68 (45.9%) that they knew very little, and 12 (8.1%) that they knew nothing about the proposed legislation. Participants were also asked about provisions in this bill that would make it punishable with a fine or up to ten years in prison and whether this would make it less likely that they engage in non-violent action. A total of 38 (25.7%) were unsure. Roughly one third of respondents, 49 (33.1%), said it would not make them less likely to engage in non-violent action, but roughly the same proportion, 44 (29.7%), indicated that it would – suggesting a chilling effect on protest as a result of this repressive legislation.

8. What's next?

As a whole, these results shed light on the difficulties faced by healthcare workers engaging in non-violent action, their motivation for engaging in such action and, importantly, when they felt such action was justified. While we are still analysing this data, Medact and the University of Greenwich hope to use the above results to inform future research and policy. We are presently writing up the above results in more detail to be published in academic journals and exploring how we could use these results to further Medact's campaigning work.

The findings will certainly inform Medact's own policies around when and how to engage health workers in non-violent direct action. Also, our results revealed that many felt somewhat isolated because of a culture in healthcare which did not support non-violent resistance. This finding suggests that more work is needed in engaging others and in providing a space for like-minded people to support one another. On this point there appears to be scope to facilitate a shared understanding of what constitutes non-violent resistance, that is, greater opportunities for healthcare workers to share ideas and actions about how policies, structures and laws that negatively impact health can be resisted. Beyond this, we hope this research will be used as a platform for further investigations in this area.

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