What Role Should Resistance Play in Training Health Professionals?

Rachel H. Ellaway, PhD, and Tasha R. Wyatt, PhD

Abstract

The role that resistance plays in medicine and medical education is ill-defined. Although physicians and students have been involved in protests related to the COVID-19 pandemic, structural racism, police brutality, and gender inequity, resistance has not been prominent in medical education’s discourses, and medical education has not supported students’ role and responsibility in developing professional approaches to resistance. While learners should not pick and choose what aspects of medical education they engage with, neither should their moral agency and integrity be compromised. To that end, the authors argue for professional resistance to become a part of medical education. This article sets out a rationale for a more explicit and critical recognition of the role of resistance in medical education by exploring its conceptual basis, its place both in training and practice, and the ways in which medical education might more actively embrace and situate resistance as a core aspect of professional practice. The authors suggest different strategies that medical educators can employ to embrace resistance in medical education and propose a set of principles for resistance in medicine and medical education.

Embracing resistance as part of medical education requires a shift in attention away from training physicians solely to replicate and sustain existing systems and practices and toward developing their ability and responsibility to resist situations, structures, and acts that are oppressive, harmful, or unjust.

... many doctors would prefer to avoid the topic of politics altogether. Unfortunately, that is no longer possible.... If we remain silent about this problem, we are shirking our duty. The result is we’ve had to become public advocates. We have no choice.

The role that resistance plays in medicine and medical education has become increasingly evident. For instance, during the COVID-19 pandemic, many physicians and students spoke out about the unjust working conditions of health care professionals, actively questioning the policies and systems that put them at unnecessary risk. Physicians and students have also been active in raising awareness of broader societal concerns, such as how Black/African American communities’ health is disproportionately affected by structural racism. Others have protested police brutality against their communities and situated racial violence as a public health concern. Such protests have a long history, but the scale and prominence of these protests have escalated of late both in the United States and beyond.

Resistance has also been associated with perceived and/or real injustices within medical education. For example, physicians and students of color in the United States have had to show resilience in often harsh training and working environments and many have also had to resist the cultures of medicine that systematically exclude or demean them to create safe places for themselves and for other individuals who have similar experiences. Additionally, students outside the United States, for instance, in Canada and the United Kingdom, have focused acts of resistance on misogyny within the health sciences and on the right to engage with the public about social concerns.

So why has resistance not been more prominent in medical education’s discourses? Why has medical education not supported students’ role and responsibility in developing professional approaches to resistance? In this article, we set out a rationale for a more explicit and critical recognition of the role of resistance in medical education. We ground this argument in the exploration of the conceptual basis for resistance in medical education, its place both in training and practice, and the ways in which medical education might better embrace and situate resistance as a core aspect of professional practice.

Conceptualizing Resistance

We conceptualize resistance as individual and collective expressions of condemnation of social harms and injustices, with the intent of stopping them, preventing them from recurring, and/or holding those responsible for them to account. In other words, resistance is a deliberate reaction aimed at remedying confining social structures and "not primarily an attitude directed against something, but for something." Resistance intersects with disobedience, which is the refusal to follow instructions or rules. Disobedience can be a form of resistance, but only if it is principled and ethical. For instance, disobedience as a form of resistance should not cause or allow harm to come to potentially vulnerable individuals, such as learners or patients. Disobedience that lacks an ethical grounding has no integrity in a professional setting. Nevertheless, resistance’s connection with disobedience can make it appear destructive and disloyal, particularly to those whose...
authority or credibility may be challenged, making it harder to pursue a path of resistance. As Fromm observed, resistance is challenging because "it is so difficult to dare to disobey, to say 'no' to power. During most of human history obedience has been identified with virtue and disobedience with sin."[14](p9)

Similarly, resistance is also related to advocacy, which involves working to improve the circumstances of certain individuals or groups by helping them to negotiate the health care system."[16] However, while resistance and advocacy both focus on effecting change, resistance is a challenge to the status quo, while advocacy seeks ways to adapt it or work around it. Tellingly, while advocacy has been debated for nearly a decade in the medical profession,[17,18] resistance has not been given the same level of consideration.

In contrast to disobedience and advocacy, resistance is purposive, principled, and potentially confrontational and can be expressed in multiple forms: public or private, active or passive, conscious or unconscious, violent or nonviolent, and civil or uncivil. These forms depend on the ideology of the specific individual or group and the nature of what is being resisted.[19] The common factor across each form of resistance is health care providers' moral obligation to know when, why, and how to work for change when a system is unjust.

Resistance can be expressed via grand gestures, such as protests of the United States' racial injustice pandemic amid the COVID pandemic,[20] or via everyday gestures, including false compliance, feigned ignorance, dissimulation, and foot-dragging.[21] These everyday gestures are relatively safe, unobtrusive, and involve little risk to the individual. They also highlight how important it is to find ways to resist a system without being excluded from it and therefore losing the ability to resist it. Resistance should therefore be proportionate to an individual's ability to continue participating in a system while also working for change within that system.

The Absence of a Resistance Discourse in Medical Education

The idea of resistance in medical education has a long history within the medical profession if one knows where to look. There have been many who have challenged orthodox thinking and practice and engaged in numerous acts of critique and dissent.[22–24] However, students are rarely exposed to these ideas as part of their studies[25] and many may fear professional retaliation, especially when obedience is rewarded and disobedience punished.[26] Nevertheless, many learners may have engaged in acts of resistance, either in extramural resistance movements (e.g., participating in civil rights or environmental causes) or through leadership in student societies. Students who are disadvantaged within existing educational systems may also engage in a variety of conscious and unconscious acts of resistance to transform the structures that create or maintain their disadvantage.[15] Acts of resistance can also reflect reactionary stances. For example, students have resisted the inclusion of the "soft" sciences into the curriculum,[27] having internalized their institution's values about how to succeed.[28] Students have also resisted the hidden and, in some cases, the null curriculum on how race and ethnicity intersect with medicine.[29] According to Shor and Freire, students have ample reason to resist because formal education is "an environment of rules, curriculum, tests, punishments, requirements, correction, remediation … [that] is based in manipulation and subordination."[30](p123)

Although those who have had these experiences are likely to have gained valuable insights into what resistance means to them, most learners have little formal orientation to when they should resist, how they should resist, and even whether resistance is a viable option for them. What if medical education went beyond socializing students to the dominant culture of the profession they aspire to join[31] and instead helped them to resist the social harms and injustices they encounter?

Embracing Resistance in Medical Education

Others have observed that medical education has had a "bleached discourse" in which the latent principles that shape the existing social order remain unaddressed and unquestioned.[32] Although medical education should emphasize service and duty, medical educators might think more about ways to train future physicians in ways that do not simply replicate and sustain existing systems and practices but in ways that consider their ability and responsibility to resist situations, structures, and acts that are oppressive, harmful, or unjust.

Without this capacity, it is unlikely that the social missions of medical schools can be fulfilled or that their social contracts can be honored.[33] To this end, we suggest 2 strategies that medical educators can employ.

First, we ask medical educators to reflect on their ethical responsibility to raise students' critical consciousness around issues of inequity and injustice in medicine and medical education.[34] To this end, educators could analyze and challenge the structures and cultures of medical education[35] by embracing the tenets of critical pedagogy.[36] Critical pedagogy is a teaching approach that attempts to help learners question and challenge dominant beliefs and practices within a given setting. Educators who teach from this perspective "unravel the ideological interests embedded in the various message systems of the school, particularly in the curriculum, modes of instruction, and evaluation procedures."[32](p111) Using critical pedagogy can help learners to question the current educational and health care systems, to critique their logics and ideologies, to identify harms and injustices perpetuated by these systems, and to consider ways of addressing these harms and injustices.

Critical pedagogy can be incorporated into many teaching settings. For instance, Kumagi and colleagues[37] noted that in small-group interactions, discussions about how medical and health issues manifest in real life often shift from abstract concepts to lived experiences. These shifts allow medical educators to leverage topics that might otherwise not make it into the curriculum. For example, educators teaching about medical error can explore how unsafe practices and cultures have contributed to medical errors and the ways these practices and cultures might be resisted. Similarly, by exploring hierarchy and privilege within medicine, quality improvement projects might question the status quo and afford new perspectives on how things might be changed for the
better. In teaching ethics, educators can help students to explore why conflicts of interest can occur and how challenges to professional integrity can be resisted. Students might be asked to reflect and comment on their own experiences of poverty and injustice as part of teaching around social determinants of health, a topic in which content is often addressed simply as a matter of facts rather than as a matter of personal life experiences. The important point is that embracing resistance in medical education does not need to add content to an already full curriculum; it can be woven into existing medical education programming.

Second, we ask medical educators to embrace the possibilities of first follower theory, which posits that social movements begin to have traction once someone who has initiated a change gains their first follower. When a movement has at least 1 follower, it becomes less risky for others to voice their dissent and thus draws more individuals into the movement. Educators can teach about resistance within medical education by drawing attention to the ways in which systems continue to do harm because nobody has challenged them. Supporting students in building collective resistance to injustice and harm can turn an individual problem into a legitimate response to shared experiences of adversity. While addressing personal concerns within the context of teaching can be helpful to students encountering implicit bias, educators should make sure they support those who have been traditionally marginalized and silenced in their resistance as well. It may be that educators are also uncertain about when and how to embrace resistance. Opportunities for colearning and shared discovery about resistance can be explored between educators and learners, possibly also drawing on patient voices and their perspectives on resistance.

In each of these 2 approaches, it is important to consider the interactions between resistance as a student and resistance as a future practitioner. Medical educators can certainly promote the capability to engage in resistance once in practice, but they can also legitimize resistance within the precincts of medical education, both as a way of preparing for practice and as a way of addressing the shortcomings and inequities within their medical education programs. However, the distinction between resisting injustice and social harm and working within imperfect organizations should also be carefully considered, as not everything should be resisted and not everything should be withstood. Resistance and resilience within institutions and systems are both possible responses to adversity. Identifying what the balance between these should be in any given circumstance is an indicator of competence.

Drawing our arguments together, we ask medical educators to explore and embrace the idea of professional resistance and the ethical duty of medical professionals to oppose aspects of their practice that diminish the profession or that create or maintain injustices or harms. Central to this is the social contract between medical education and society. The social contract is not fixed and unalterable, rather it can and should be challenged and rewritten if its tenets are not met or when those involved no longer consent to the conditions under which it is executed. After all, the ability to resist and dissent is a key aspect of any community of practice; a profession such as medicine must allow for resistance if it is to retain its integrity and viability.

**List 1**

**Principles for Resistance in Medicine and Medical Education**

Resistance needs to be:
- Affirmative and principled: It should be for something rather than against something.
- Deliberate: It should be undertaken intentionally and mindfully.
- Proportionate: It should be sufficient to achieve its ends.
- Constructive: It should be about finding and building solutions.

Resisters need to be:
- Courageous and committed: They should demonstrate fortitude as change agents.
- Precise: They should be clear about what is being resisted, why, and how.
- Mindful: They need to be aware of how their ideas are interlaced with other issues and who is likely to benefit and lose from acts of resistance.
- Accountable: They should act responsibly and be ready to account for their actions.

Physicians need to be:
- Citizens: They are both professionals and individuals with personal convictions. Being a physician should not compromise those convictions, but convictions should be considered critically and carefully in terms of their impact on being a health professional.
- Champions: They should advocate for themselves, for their profession, and for society, particularly for those who are disadvantaged by social or health care inequities.
- Stewards: They should care for their profession, which may mean challenging its standards and tenets if they become obstacles to professional integrity or if they no longer serve the best interests of particular communities or society as a whole.

**Implications**

We have set out a conceptual basis both for teaching about resistance and for how to resist in medical education, and we have argued for it to be made more explicit both in medical practice and medical education. We have summarized and abstracted the main points of our thesis as a set of principles in List 1. In advancing this argument, we would like to note that teaching about resistance does not oblige all students to become physician change agents, nor does it oblige that those who do take part in resistance should do it all of the time. Rather, resistance should be understood as a legitimate part of professional practice when the need arises. Resources that can be used to develop thinking and practice in and around resistance include Giroux’s *Theory and Resistance in Education: Towards a Pedagogy for the Opposition* and Kelly and Medina’s *Rebels at Work: A Handbook for Leading Change From Within*.

Although resistance is, as we have argued, an underconsidered topic in medical education, the debate over whether medical education should produce agents of social change or focus instead on technical or research skills is a recurring theme in the field. It is interesting to note that different sides of the argument are themselves
resisting, as opposing resistance only confirms its inescapable presence. Indeed, competencies from 3 prominent competency frameworks—the Accreditation Council for Graduate Medical Education's systems-based practice core competency in the United States, the Royal College of Physicians and Surgeons of Canada's CanMEDS health advocate and leader roles, and the General Medical Council's capabilities in safeguarding vulnerable groups domain in the United Kingdom—could be interpreted as encompassing resistance to some extent. However, thinking about resistance more explicitly and expansively in medical education could help others, such as patients in their interactions with health care systems, not least by acknowledging that systems and those within them do not always act in benevolent ways.

Limitations

We acknowledge that we have not presented empirical evidence in support of this thesis. Rather, we approached this issue deductively, building a logical argument regarding the role of resistance in medicine and medical education based on moral and ethical philosophy in education and drawing on specific cases from health professions education. This does not mean that research and critical inquiry into the role of resistance in medical education is not necessary, only that a space for such inquiry needs to be established first. Having done so here, we plan to explore these issues further through our own research programs, and we invite others to join this conversation.

We also acknowledge that resistance is contextualized; it will likely look different in medical education cultures that are more progressive than it will in medical education cultures that have a more traditional or conservative approach to training. Those programs that have adopted a greater sense of social responsibility may find that our definition of resistance may not go far enough or does not fit with their educational or practice contexts. For this reason, we need empirical research that considers different forms and expressions of resistance in medical education, different foci of resistance, and different approaches to student engagement with resistance in their training and subsequent practice.

While our focus has been on medical education and medicine in this article, the principles we have outlined should logically apply to other health care disciplines. We leave it to others to establish whether and how this might be the case. However, the tensions between different health care disciplines in terms of hierarchy, respect, and legitimacy will likely play a part in this translation, which in turn has implications for medicine and medical education. Also, in presenting a broad landscape of resistance in medical education, we have not explored the consequences of different courses of action. For instance, our inclusion of the first follower theory could be further unpacked in terms of the venues through which learners might be encouraged to establish a following. For example, while social media are essential for influencers, they can also be grueling in terms of the insults and threats aimed at those who take a stand on contentious issues. Primum non nocere (first, do no harm) should guide educators in this regard.

In advancing our ideas, we acknowledge that, as White North American women, we are situated in privileged positions working as allies and advocates, rather than speaking as direct representatives of all marginalized or equity-seeking groups in medicine or medical education. We have argued for a place for resistance in medicine and medical education in principle rather than specifying what resistance should look like for different groups and issues. We also acknowledge that some readers may be uncomfortable with our arguments, perhaps seeing resistance as a personal matter and not one that should be embraced by the profession. We ask them to consider this reaction to also be a form of resistance, validating our thesis even as it challenges it. Moreover, resistance is a matter for everyone, no matter what their ideological position. It is for those on the right as well as those on the left, for the conservatives as well as the progressives; the principles we have outlined should logically apply to other health care disciplines. We leave it to others to establish whether and how this might be the case. However, the tensions between different health care disciplines in terms of hierarchy, respect, and legitimacy will likely play a part in this translation, which in turn has implications for medicine and medical education. Also, in presenting a broad landscape of resistance in medical education, we have not explored the consequences of different courses of action. For instance, our inclusion of the first follower theory could be further unpacked in terms of the venues through which learners might be encouraged to establish a following. For example, while social media are essential for influencers, they can also be grueling in terms of the insults and threats aimed at those who take a stand on contentious issues. Primum non nocere (first, do no harm) should guide educators in this regard.

Conclusion

In summary, we ask medical educators to embrace learner resistance as a legitimate part of medical education so that our learners develop a sense of agency, proportionality, and responsibility to resist aspects of systems that they find unjust or harmful and create change where it is needed. While learners should not pick and choose what aspects of medical education they engage with, neither should their moral agency and integrity be compromised. For, as Dr. Martin Luther King Jr. said, "One has not only a legal but a moral responsibility to obey just laws. Conversely, one has a moral responsibility to disobey unjust laws." 57

Acknowledgments: The authors dedicate this commentary to all physicians and educators who have resisted unjust and harmful systems in medicine and medical education, knowing what they risk in doing so.

Funding/Support: None reported.

Other disclosures: None reported.

Ethical approval: Reported as not applicable.

Disclaimers: The opinions and assertions expressed herein are those of the author(s) and do not necessarily reflect the official policy or position of the Uniformed Services University of the Health Sciences or the Department of Defense.

R.H. Ellaway is professor, Department of Community Health Sciences, and director, Office of Health and Medical Education Scholarship, Cumming School of Medicine, University of Calgary, Calgary, Alberta, Canada; ORCID: https://orcid.org/0000-0002-3759-6624.

T.R. Wyatt was associate professor, Educational Innovation Institute, Medical College of Georgia, Augusta, Georgia, at the time of writing. She is currently associate director, Center for Health Professions Education, and associate professor, Department of Medicine, F. Edward Hebert School of Medicine, Uniformed Services University of the Health Sciences, Bethesda, Maryland; ORCID: https://orcid.org/0000-0002-0071-5298.

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